

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

05665

Reg. Dist. No. 332

05677

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 309 Elmwood St				STREET ADDRESS (If rural give location) 309 Elmwood St			
3. NAME OF DECEASED (Type or Print) WILLIAM MANSFIELD AUSTIN				4. DATE OF DEATH (Month) MAY (Day) 9 (Year) 19 57			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH August 8, 1878		9. AGE last birthday 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired House Painter (Painting)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Edward Austin				14. MOTHER'S MAIDEN NAME Julia Base			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Cynthia C. Austin (Wife) 309 Elmwood St. Salisbury, Maryland	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
570.2 IMMEDIATE CAUSE (A) Presenting symptoms				General arteriosclerosis		5 yrs	
ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				Arteriosclerotic C-V Disease		years	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 4-22-57		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 50 to 19 57, that I last saw the deceased alive on 19 57, and that death occurred at 6:45 A.M. from the causes and on the date stated above.							
SIGNATURE Dr. Wm. D. Gray				ADDRESS (Street, city, town, state) M.D. 334 Camden Ave. Salisbury, Md.		DATE SIGNED May 9 1957	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 11, 1957		NAME OF CEMETERY OR CREMATORY Rehobeth Cemetery		LOCATION (City, town, or county) (State) Somerset Co. Maryland	
24. REC'D BY REGISTRAR MAY 10 1957		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY, MARYLAND			

CERTIFICATE OF DEATH

Form No. 10

1. Name of deceased (Print or type)

2. Date of death (Month, day, year)

3. Place of death (City, county, State)

4. Age at death (Years, months, days)

5. Sex (Male or Female)

6. Race

7. Date of birth

8. Place of birth

9. Cause of death (Immediate)

10. Cause of death (Underlying)

11. Medical certificate

12. Signature of physician

13. Signature of registrar

14. Signature of coroner

15. Signature of funeral director

16. Signature of health officer

17. Signature of registrar

18. Signature of coroner

19. Signature of funeral director

20. Signature of health officer

BUREAU V. 2

MAY 10 1957

RECEIVED

21. Signature of registrar

22. Signature of coroner

23. Signature of funeral director

24. Signature of health officer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9,10,11,12,13,14 Filing 216 6-10-57 et

CERTIFICATE OF DEATH

05678

05666

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Paince's Anne</u> 19X02 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>A7D #2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George</u> <u>Beauchamp</u>		4. DATE OF DEATH Month Day Year <u>May</u> <u>26</u> <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 21, 1900</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Saw Mill</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>John Beauchamp</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Hatten</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Normal Incompetence</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Hypertensive Heart & Hunt Block</u> DUE TO <u>Hypertension & Atherosclerosis</u> (c) <u>thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/24/57</u> , 19 to <u>5/26/57</u> , 19, that I last saw the deceased alive on <u>5/26/57</u> , 19, and that death occurred at <u>11:20 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Mr. Carrie I. Hearn</u> M.D.		ADDRESS (Street, city or town, state) <u>226 N. Hinesman St.</u> DATE SIGNED <u>May 31 1957</u>	
PHYSICIAN'S NAME (Type) <u>DR. CARRIE I. HEARN</u>		<u>226 N. Hinesman St.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-29-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>M. B. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Focomake Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin R. Wilson</u>		24a. REC'D BY REGISTRAR <u>Mary H. Follmer</u> 24b. REGISTRAR'S SIGNATURE	

U. S. BUREAU OF INVESTIGATION

MAY 31 1957

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05734

CERTIFICATE OF DEATH

05667

232

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn St (R.D. # 5)				STREET ADDRESS Glenn St (R.D. # 5)		(If rural give location)	
3. NAME OF DECEASED (Type or Print) ELIZA L BELL				4. DATE OF DEATH (Month) MAY (Day) 6 (Year) 19 57			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH December 22, 1869	9. AGE last birthday 87 yrs.	IF UNDER 1 YEAR Months 4 Days 14		IF UNDER 24 HRS. Hours 14 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George T. Mears				14. MOTHER'S MAIDEN NAME Margaret Belote			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Pauline Brittingham (Daughter) R.D. #5 Glenn St Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) Cerebro Vascular Accident				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) Serious							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while et work <input type="checkbox"/>		21e. INJURY OCCURRED While et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9/23 , 19 55 , to 5/6 , 19 57 , that I last saw the deceased alive on 1/24 , 19 57 , and that death occurred at 10:00A , from the causes and on the date stated above.							
SIGNATURE Dr. Andrew Mitchell M.D.				ADDRESS (Street, city, town, state) M.D. Maryland Ave. Salisbury, Maryland			
DATE SIGNED May 7 1957							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 8, 1957		NAME OF CEMETERY OR CREMATORY Parsons Cemetery		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR DATE MAY 10 1957		REGISTRAR'S SIGNATURE Mary J. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HOLLOWAY & COMPANY - SALISBURY, MARYLAND			

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
George J. Harris		Male		67	
DATE OF DEATH		PLACE OF DEATH		CITY	
October 10, 1957		Home		Baltimore	
DATE OF BIRTH		PLACE OF BIRTH		CITY	
March 10, 1890		Maryland		Baltimore	
DATE OF DEATH		PLACE OF DEATH		CITY	
October 10, 1957		Home		Baltimore	
DATE OF BIRTH		PLACE OF BIRTH		CITY	
March 10, 1890		Maryland		Baltimore	
DATE OF DEATH		PLACE OF DEATH		CITY	
October 10, 1957		Home		Baltimore	
DATE OF BIRTH		PLACE OF BIRTH		CITY	
March 10, 1890		Maryland		Baltimore	

BUREAU V. S.

MAY 10 1957

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POSTAL & TELEGRAPH - BALTIMORE, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05679

CERTIFICATE OF DEATH

Reg. Dist. No. 322

05668

1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OCEAN CITY 23X22	
d. NAME OF HOSPITAL (If not in hospital, give street address) PENINSULA GENERAL HOSPITAL		d. STREET ADDRESS ST. LOUIS AVENUE	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN BERGMAN		4. DATE OF DEATH Month Day Year MAY 9 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3, 1872
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 84	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Fish	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) X (If yes, give war and dates of service) X		16. SOCIAL SECURITY NO. XXX	
17. INFORMANT Allen Bergman Ocean City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate with metastases 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.9 Anteriosclerosis, generalized 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 28, 1957 , to May 9, 1957 , that I last saw the deceased alive on May 9th, 1957 , and that death occurred at 3:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Raymond M. You M.D. 707 Camden Ave. Salisbury, Md.			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 11, 57	
22c. NAME OF CEMETERY OR CREMATORY Zion Church Yard		22d. LOCATION (City, town, or county) (State) Bishopville, MD	
23. FUNERAL DIRECTOR'S SIGNATURE Peter H. Kelly, Salisbury, Del.		ADDRESS 707 Camden Ave. Salisbury, Md.	
24a. REC'D BY REGISTRAR DATE 5/13/57		24b. REGISTRAR'S SIGNATURE Mary Holloway	

CERTIFICATE OF DEATH

DECEASED JENNIFER GENERAL HOSPITAL 32 days 32 days		OCCASION 32 days 32 days	
NAME WHITE WHITE		SEX F F	
AGE 32 32		DATE OF BIRTH 1924 1924	
PLACE OF BIRTH BALTIMORE BALTIMORE		PLACE OF DEATH BALTIMORE BALTIMORE	
OCCUPATION N/A N/A		CAUSE OF DEATH N/A N/A	
SIGNATURE BERGMAN BERGMAN		DATE MAY 13 1957 MAY 13 1957	

BUREAU V. 2

MAY 13 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05680

CERTIFICATE OF DEATH

Reg. Dist. No.

05669
337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS (If rural give location) 235 Hazel Ave.			
3. NAME OF DECEASED (First) (Middle) (Last) WILLIAM E BONNEVILLE				4. DATE OF DEATH (Month) (Day) (Year) MAY 25 th 19 57			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Sept. 21, 1878	9. AGE last birthday 78 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Barber		10b. KIND OF BUSINESS OR INDUSTRY Barber		11. BIRTHPLACE (State or foreign country) R.D.# Snow Hill, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Selby Bonnevill				14. MOTHER'S MAIDEN NAME Catherine Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Ellegood Phillip Bonnevill (Wife) 235 Hazel Ave. Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
581.0 IMMEDIATE CAUSE (A) Lasts intestinal hemorrhage							
ANTECEDENT CAUSE(S) DUE TO (B) Cirrhosis of liver						2 wks	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Benzoin protatic hypertrophy; coronary artery disease							
19a. DATE OF OPERATION 6/10/57		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at..... 3:55A.M., from the causes and on the date stated above.							
SIGNATURE Dr. Wm. H. Fisher Jr.				ADDRESS (Street, city, town, state) DATE SIGNED			
W. H. Fisher Jr.				M.D. Medical Center - Salisbury, Md. May 28 1957			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial-		DATE THEREOF May 28, 1957		NAME OF CEMETERY OR CREMATORY Parsons Cemetery		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND			
DATE MAY 31 1957		REGISTRAR'S SIGNATURE Mary H. Holloway					

CERTIFICATE OF DEATH

Name of Deceased William H. Johnson		Date of Death May 21, 1957	
Sex Male		Age 68	
Race White		Marital Status Married	
Usual Residence 1234 Elm Street, Baltimore, Md.		Place of Death Home	
Cause of Death Coronary Thrombosis		Contributing Cause Hypertension	
Physician Dr. J. H. Smith		Medical Examiner Dr. A. B. Jones	
Burial Place St. Mary's Cemetery		Date of Burial May 23, 1957	

BUREAU V. 3

MAY 31 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05735

CERTIFICATE OF DEATH

05670

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Pocomoke City X/</u>	
c. LENGTH OF STAY IN 1b <u>3 years</u>		d. STREET ADDRESS <u>RFD #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ocean City Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sadie</u> Middle <u>Powell</u> Last <u>Boston</u>		4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 7, 1875</u> 9. AGE (In years lost birthday) <u>81</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Powell</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>-----</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>J. Ralph Boston, Stockton, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/16/53</u> , 19 <u>53</u> , to <u>5/21</u> , 19 <u>57</u> that I last saw the deceased alive on <u>5/21</u> , 19 <u>57</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. C. Mitchell</u> M.D. <u>2/1 Maryland - Salisbury Md</u>		DATE SIGNED <u>5/25/57</u>	
PHYSICIAN'S NAME (Type) <u>A. C. Mitchell, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 25, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u> ADDRESS <u>Pocomoke, Md.</u>		24a. REC'D BY REGISTRAR <u>May 25 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. S.

MAY 28 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 532

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u> 23X2.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>23X2.2</u>			
3. NAME OF DECEASED (Type or print) <u>Victor</u> First <u>HAROLD</u> Middle <u>BOSTON</u> Last				4. DATE OF DEATH <u>MAY 15</u> Month <u>15</u> Day <u>1957</u> Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 18, 1895</u> 62 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN STORE</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ELTON BOSTON</u>				14. MOTHER'S MAIDEN NAME <u>MARY A. BURBAGE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>28-24420</u>		17. INFORMANT <u>Mrs V. H. BOSTON</u> Address <u>BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>587.0</u> DUE TO <u>Acute Hemorrhagic pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>2 days</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>5-13</u> , 19 <u>57</u> , to <u>5-15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5-15</u> , 19 <u>57</u> , and that death occurred at <u>8:35 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William H. Fisher</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury Md.</u>			
PHYSICIAN'S NAME (Type) <u>William H. Fisher</u>				DATE SIGNED <u>5/16/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>May 19, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Buckingham</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna D. Busby</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR <u>DATE 5/22/57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Hollaway</u>	

BUREAU V. 3

MAY 22 1957

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy **may** be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05672

05682

CERTIFICATE OF DEATH

Reg. Dist. No. **337**

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 335 Camden Ave				STREET ADDRESS (If rural give location) 335 Camden Ave.			
3. NAME OF DECEASED (Type or Print) LAURINAS LAURENZ (First) BRASKA BRASKY (Last)				4. DATE OF DEATH (Month) May (Day) 7 (Year) 19 57			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH August 15, 1891		9. AGE last birthday 65 yrs.	IF UNDER 1 YEAR Months 6 Days 22	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer (Water Front) Longshoreman			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kaunas, Lithuania		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Peter Braska (or) Brasky				14. MOTHER'S MAIDEN NAME Constance (Unk)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes W.W. # 1			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Bertha Cooper (Daughter) 335 Camden Ave. Salisbury, Maryland		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) cerebral vascular accident						INTERVAL BETWEEN ONSET AND DEATH 5 days	
ANTECEDENT CAUSE(S) DUE TO (B) arterio-sclerosis						2	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Hypertension, hyperactive heart disease						2	
19a. DATE OF OPERATION 443X				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 55 to May 7th 19 57, that I last saw the deceased alive on May 6th 19 57, and that death occurred at 1:15 A.M. from the causes and on the date stated above.							
SIGNATURE Dr. L. V. Schler M.D.				ADDRESS (Street, city, town, state) M.D. 303 E. St. Delmar, Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF May 10, 1957		NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	
24. REG'D BY REGISTRAR MAY 10 1957				REGISTRAR'S SIGNATURE Mary J. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY	
DATE				ADDRESS SALISBURY MARYLAND			

CERTIFICATE OF DEATH

REGISTRATION NO.

A. DEATH CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

BUREAU V. 2

MAY 10 1957

RECEIVED

BALTIMORE & COMPANY

RECEIVED

CERTIFICATE OF DEATH

05673

Reg. Dist. No.

05683

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 3 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Riverside Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Margaret First Carrie Middle Brittingham Last				4. DATE OF DEATH Month May Day 6 Year 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 31, 1863		9. AGE (In years last birthday) yrs. 94	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Alfred D. Merrill				14. MOTHER'S MAIDEN NAME Harriett J. Lambden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs Hattie Walls, Pocomoke City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/5 , 19 54 , to 5/6 , 19 57 , that I last saw the deceased alive on 5/6/57 , 19 57 , and that death occurred at 5:40 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Fred R. Gramse M.D. Salisbury, Md. PHYSICIAN'S NAME (Type) Fred R. Gramse, M.D. 402 S. Division St., Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 8, 1957		22c. NAME OF CEMETERY OR CREMATORY Baptist Cemetery		22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson				ADDRESS Pocomoke, Md.		24a. REC'D BY REGISTRAR MAY 10 1957	
				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18
Items 7 & 9, Film G216, 6/6/57 bh
05684
CERTIFICATE OF DEATH

05674

Reg. Dist. No.

932

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRINCESS ANNE</u> 1902 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL Hospital</u>		d. STREET ADDRESS <u>PRINCESS ANNE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD</u> <u>CANNON</u>		4. DATE OF DEATH Month Day Year <u>MAY</u> <u>29th</u> <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLOR</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>48</u> yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Saw mill</u>	
10a. BIRTHPLACE (State or foreign country) <u>Princess Anne, MD</u>		10b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. FATHER'S NAME <u>Hazel Cannon</u>		12. MOTHER'S MAIDEN NAME <u>Harriet A. Hudson</u>	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		14. SOCIAL SECURITY NO. <u>Amie Coltrane, Princess Anne, MD</u>	
15. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
16a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		16b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
17a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		17b. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
17c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		17d. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/28</u> , 19 <u>57</u> , to <u>5/29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/29</u> , 19 <u>57</u> , and that death occurred at <u>3:22 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A C Mitchell</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>5/29/57</u>	
PHYSICIAN'S NAME (Type) <u>Andrew O. Mitchell</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/3/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Mary</u>		22d. LOCATION (City, town, or County) (State) <u>West Port office, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. James</u>		24a. REC'D BY REGISTRAR <u>6-1-57</u>	
ADDRESS <u>Princess Anne, MD</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

RECEIVED
MAY 19 1964
U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF THE ASSISTANT SECRETARY FOR PUBLIC AFFAIRS
WASHINGTON, D.C. 20461

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9-55-75

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05675

CERTIFICATE OF DEATH

05736

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL and give nearest town) Hebron (Rural)		LENGTH OF STAY (In this place) 00		CITY (If outside corporate limits, write RURAL and give nearest town) Hebron (Rural)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D.# 1		STREET ADDRESS (If rural give location) R.D.# 1					
3. NAME OF DECEASED (First) HARVEY (Middle) HOWARD (Last) CARLTON				4. DATE OF DEATH (Month) May (Day) 9 (Year) 1957			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Feb. 5, 1883	9. AGE last birthday 74 yrs.	IF UNDER 1 YEAR Months 3 Days 4		IF UNDER 24 HRS. Hours 4 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Chico, California		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles C. Carlton				14. MOTHER'S MAIDEN NAME Mary Louise Markham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) W.W.# 1		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Miss. Alma V. Carlton (Daughter) R.D.# 1 Hebron, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) Coronary Thrombosis						1 day	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 9th 1957, to May 9th 1957, that I last saw the deceased alive on May 9th 1957, and that death occurred at 10:10 P.M. from the causes and on the date stated above.							
SIGNATURE <i>Dr. Wm. Enrich</i>				ADDRESS (Street, city, town, state) M.D. Hebron, Maryland		DATE SIGNED May 10th 1957	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 11, 1957		NAME OF CEMETERY OR CREMATORY Greenfield Cemetery		LOCATION (City, town, or county) (State) Rockville Center - L.I. New York	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Mary Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY, MARYLAND			
DATE 5/13/57							

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BUREAU A.

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Index

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 4, 11, File G216 6-5-57 et
05685
CERTIFICATE OF DEATH

05676
231
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salis Md.</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>514 Booth St. Salis. Md.</u>				d. STREET ADDRESS <u>15 Snuff Hill</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Mae</u> Last <u>Collins</u>				4. DATE OF DEATH Month <u>5</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 30, 1907</u> 49 yrs.	
9. AGE (In years last birthday)		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Head-Creek, Maryland</u>	
13. FATHER'S NAME <u>John Miles</u>				14. MOTHER'S MAIDEN NAME <u>Margrette Dashiell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Thomas N. Collins</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia (Bronchial)</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>20 May 1957</u> to <u>29 May 1957</u> that I last saw the deceased alive on <u>29 May 1957</u> and that death occurred at <u>7 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>652 W. Main St. Salisbury Md.</u> DATE SIGNED <u>29 May 57</u>							
ACTUAL SIGNATURE <u>E. A. Furnell</u>		PHYSICIAN'S NAME (Type) <u>E. A. Furnell, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/30/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>		22d. LOCATION (City, town, or county) (State) <u>Salis. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Stewart</u>				ADDRESS <u>West Road-Salis. Md.</u>		24a. REC'D BY REGISTRAR <u>May 31 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary St. Holloway</u>			

MAY 31 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05677

05686

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>1 DAY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - STOCKTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Peninsular General Hospital</u>				d. STREET ADDRESS <u>RFD #3 23X12</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Collins</u> Last <u>May</u>		4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1957</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APR. 1, 1878</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>- UNKNOWN -</u>		14. MOTHER'S MAIDEN NAME <u>- UNKNOWN -</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-36-0831</u>		17. INFORMANT <u>Box 285 MARY STATION, SNOW HILL, MARYLAND</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary TB (Far Advanced)</u> DUE TO <u>002X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Broncho Pneumonia</u> DUE TO <u>Few days</u> (c) <u>Malnutrition - Starvation</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>274X Addison Disease</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 5, 1957</u> to <u>May 6, 1957</u> , that I last saw the deceased alive on <u>May 6, 1957</u> , and that death occurred at <u>1:35</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Herbert Semple</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>5/8/57</u>			
PHYSICIAN'S NAME (Type) <u>G. Herbert Semple</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-11-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAUL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>RURAL-STOCKTON, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Denny Watson</u>				ADDRESS <u>PO BOX 100, MD</u>		24a. REC'D BY REGISTRAR <u>5/13/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>			

CERTIFICATE OF DEATH

BUREAU V. S.

MAY 13 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05678
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 332
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen. Gen. Hospital					d. STREET ADDRESS R.D.#			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First WILLIAM		Middle GREENSBURY		Last COOPER		4. DATE OF DEATH Month MAY Day 6 th Year 19 57		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 8, 1875		9. AGE (In years last birthday) 81 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Willards, Maryland			12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Joseph Cooper					14. MOTHER'S MAIDEN NAME Nancy Littleton					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. Preston W. Cooper (Son) R.D.# Willards, Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 916.0 hugocendrial degeneration DUE TO A.S.C. & D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 916.0 hugocendrial degeneration DUE TO A.S.C. & D. (c)										INTERVAL BETWEEN ONSET AND DEATH you you
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2nd & 3rd Burns left leg										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Burning weeds caught trousers on fire								
20c. TIME OF INJURY Month, Day, Year One 4-15-1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Yard of home		20f. (City or town) Wic.		(State) Wic.		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE Earl L. Royer					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED
EXAMINER'S NAME (Type) Dr. Earl L. Royer					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					May 7 1957
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 8, 1957		22c. NAME OF CEMETERY OR CREMATORY Pittsville Cem. (Old Part)			22d. LOCATION (City, town, or county) Pittsville, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.					24a. REC'D BY REGISTRAR MAY 10 1957		24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
J. Edgar Hoover		Male		58		White		May 10, 1967		Washington, D.C.	
Occupation		Cause of Death		Manner of Death		Signature of Examiner		Signature of Coroner		Signature of Physician	
Director, FBI		Heart Disease		Natural		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover	
Residence		Date of Birth		Date of Admission to Hospital		Date of Discharge from Hospital		Date of Death		Date of Burial	
Washington, D.C.		May 10, 1967		May 10, 1967		May 10, 1967		May 10, 1967		May 10, 1967	

BUREAU V. 2

MAY 10 1967

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05679

05737

CERTIFICATE OF DEATH

Item 4 Film G216 6-12-57 et

Reg. Dist. No. 33 ✓

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 4 hours after death. The bottom copy shall be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH COUNTY <u>Wicomico</u> <u>md.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Trullout</u> TOWN <u>357ms</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rural</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Wicomico</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Trullout</u> TOWN <u>357ms</u> STREET ADDRESS (If rural give location) <u>Rural</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Julia</u> <u>Corbin</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May</u> <u>28</u> <u>19 57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>1889</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days <u>6</u> <u>8</u>		IF UNDER 24 HRS. Hours Min. <u>19</u> <u>57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Sidney Bowen</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Townsend</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-30-8241</u>		17. INFORMANT & ADDRESS <u>Edmond Cattman</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 443X IMMEDIATE CAUSE (A) <u>Hypertension Cardiovascular Disease</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertension</u>				18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION <u>593X Nephritis</u>			
21e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 29, 1957</u> , to <u>May 29, 1957</u> , that I last saw the deceased alive on <u>May 29, 1957</u> , and that death occurred at <u>3:06</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Herbert Sewell</u>				DATE SIGNED <u>6/3/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>6-2-57</u>		NAME OF CEMETERY OR CREMATORY <u>West Park Office</u>		LOCATION (City, town, or county) (State) <u>West Park Office</u>	
24. REC'D BY REGISTRAR <u>Mary Holloway</u>		REGISTRAR'S SIGNATURE <u>Mary Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edmond Cattman</u>			
DATE <u>JUN 6 1957</u>							

CERTIFICATE OF DEATH

STATE OF NEW YORK

1. NAME OF DECEASED

John Doe

John Doe

John Doe

2. PLACE OF DEATH

New York City

New York City

New York City

3. DATE OF DEATH

June 5, 1957

June 5, 1957

June 5, 1957

4. TIME OF DEATH

10:00 AM

10:00 AM

10:00 AM

5. CAUSE OF DEATH

Heart Disease

Heart Disease

Heart Disease

6. PLACE OF BIRTH

New York City

New York City

New York City

7. SEX

Male

Male

Male

8. AGE

45

45

45

9. OCCUPATION

Teacher

Teacher

Teacher

10. SIGNATURE OF DECEASED

John Doe

John Doe

John Doe

11. SIGNATURE OF WITNESSES

John Doe

John Doe

John Doe

BUREAU V. S.

JUN 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05688

CERTIFICATE OF DEATH

05680

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>2 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>206 MARKET STREET</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>H.</u> Last <u>COSTEN</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>10</u> Year <u>19 57</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 14, 1872</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>DR. ISAAC T. COSTEN</u>				14. MOTHER'S MAIDEN NAME <u>OLIVIA ADAMS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MISS OLIVIA J. COSTEN, POCOMOKE M.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Heart Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 8, 1957</u> to <u>May 10, 1957</u> that I last saw the deceased alive on <u>May 9, 1957</u> and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Schure</u> M.D.				ADDRESS (Street, city or town, state) <u>Medical Center Salisbury 5/10/57</u>			
DATE SIGNED <u>5/10/57</u>							
PHYSICIAN'S NAME (Type) <u> </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-12-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PITTS CREEK PRESBYTERIAN</u>		22d. LOCATION (City, town, or county) (State) <u>POCOMOKE CITY MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry A. Watson</u>				ADDRESS <u>POCOMOKE, M.D.</u>		24a. REC'D BY REGISTRAR DATE <u>5/13/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary Hollamby</u>							

RECEIVED
MAY 13 1957
BUREAU V. 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05689

CERTIFICATE OF DEATH

05681

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>PENINSULA General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Crockett</u>				4. DATE OF DEATH Month Day Year <u>May 7 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 7, 1957</u>	
9. AGE (In years lost birthday) yrs. <u>41</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>7</u>				13. FATHER'S NAME <u>Winfred Ruben Crockett</u>			
14. MOTHER'S MAIDEN NAME <u>7</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Erythroblastosis fetalis, severe, 770.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5/7</u> , 19 <u>57</u> , to <u>5/7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/7</u> , 19 <u>57</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. H. Sunderson</u> M.D.				ADDRESS (Street, city or town, state) <u>926 N. Division St Salisbury, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Salisbury, Md.</u>				DATE SIGNED <u>5/8/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5-8-57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Wicomico, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>DATE 5-8-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>			

2082263XV3

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

Register No.

MARYLAND

BUREAU V. 3

MAY 10 1957

RECEIVED

K. H. [Signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05682
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 332
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Wicomico</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whaleyville Md</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>					d. STREET ADDRESS <u>23x22</u>					
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Dale</u> Last <u>Dale</u>					4. DATE OF DEATH Month <u>5</u> Day <u>3</u> Year <u>19 57</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 17, 1936</u>		9. AGE (In years last birthday) <u>20</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lab</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Wicomico Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Wm Green</u>					14. MOTHER'S MAIDEN NAME <u>Cecilia Dale</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Beatrice Dale</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>591X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Acute tubular nephritis</u> (c) <u> </u> DUE TO (a), stating the underlying cause last. (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
22. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>5-6-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pulcherts Chapel Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Whaleyville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M West</u>					ADDRESS <u> </u>		24a. REC'D BY REGISTRAR DATE <u>5/14/57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Hollaway</u>	

DATE SIGNED

5-6-57

WEST VIRGINIA STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. H.

14 1957

RECEIVED

RECEIVED MAR 27 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05738

05683

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wiconico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Wiconico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural) Salisbury	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Salisbury (Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Zion Rd.		d. STREET ADDRESS Cherry Way # 40	
3. NAME OF DECEASED (Type or print) First NAONI Middle WATSON Last DAVIS		4. DATE OF DEATH Month MAY Day 18 Year th 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1901
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee (Pants-Factory Worker)		10b. KIND OF BUSINESS OR INDUSTRY Hebron, Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Minos Washington Watson		14. MOTHER'S MAIDEN NAME Nora Bailey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Litty Bayard (Sister)		Address 418 W. College Ave. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident. 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Noturol causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Earl L. Royer, M.D.		DATE SIGNED May 21 1957	
EXAMINER'S NAME (Type) Dr. Kendrick McCullough		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Pen. Gen. Hospital-Salisbury	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 22, 1957	22c. NAME OF CEMETERY OR CREMATORY Hebron Cemetery	22d. LOCATION (City, town, or county) (State) Hebron, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR DATE 5/23/57	
		24b. REGISTRAR'S SIGNATURE Mary Hollaway	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Ref Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death	
John Doe		45		Male		White		Married		Teacher		Heart Disease		Home	
Date of Death		Time of Death		Place of Death		City		County		State		Hospital		Physician	
May 23, 1957		10:30 AM		Home		Baltimore		Anne Arundel		Maryland		St. Mary's		Dr. J. Smith	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Witness		Signature of Witness		Signature of Witness		Signature of Witness	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 1

MAY 23 1957

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

05691 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06889

Items 8 & 9, Film G217, 6/21/57 fcy

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>226 Delaware St.</u>		d. STREET ADDRESS <u>226 Delaware St.</u>	
3. NAME OF DECEASED (Type or print) <u>Sarah E Davis</u>		4. DATE OF DEATH Month <u>5</u> Day <u>30</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>O</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 29, 1919</u>
9. AGE (In years last birthday) <u>38</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoptown Md</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Oralanda Ennis</u>		14. MOTHER'S MAIDEN NAME <u>Sedonia Evans</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>3</u>	
17. INFORMANT <u>Bessie Powell</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cervical dislocation</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>983x</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Minutes.</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Family quarrel.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>7-8 P. m.</u> <u>5-30</u> 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Salisbury</u> (County) <u>Wicomico</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L Royer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>6-4-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-3-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Shoptown Cem</u>		22d. LOCATION (City, town, or county) <u>Shoptown Md</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
		24b. REGISTRAR'S SIGNATURE <u>Mary V. Holloway</u>	

JUN 17 1957

RECEIVED

JUN 17 1957

BUREAU V. 3

FOR STATE
HEALTH DEPT.

M

05692

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05684

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b X 2 Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 603 Rose St.		d. STREET ADDRESS 1 603 Rose St.	
3. NAME OF DECEASED (Type or print) Robert		4. DATE OF DEATH Month 5 Day 25 Year 19 57	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1922
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Ga
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ?		16. SOCIAL SECURITY NO. ?	17. INFORMANT Mrs Farmer Address N.Y.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Ischemic Heart Failure Conditions, if any, which gave rise to immediate cause (b) Coronary Occlusion (c) ? DUE TO ? cause last.			INTERVAL BETWEEN ONSET AND DEATH 5 Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Carl H. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF 5-28-57	22c. NAME OF CEMETERY OR CREMATORY Green Rose Cem
23. FUNERAL DIRECTOR'S SIGNATURE Brooks M. Clark		22d. LOCATION (City, town, or county) (State) Salisbury Md	24a. REC'D BY REGISTRAR JUN 6 1957
ADDRESS Salisbury Md		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. E.

JUN 6 1957

RECEIVED

CERTIFICATE OF DEATH

05693

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS 424 Dover St		(If rural give location)	
3. NAME OF DECEASED (First) (Middle) (Last) MARY LOIS FLANNERY				4. DATE OF DEATH (Month) (Day) (Year) MAY 25th 19 57			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH May 29, 1905	9. AGE last birthday 51 yrs.	IF UNDER 1 YEAR Months 11 Days 26	IF UNDER 24 HRS. Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James Richard Higgins				14. MOTHER'S MAIDEN NAME Goldie Estelle Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. J. Stewart Flannery (Husband) 424 Dover St. Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) Cerebral Vascular Accident				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) Hypertension							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING - TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/9/57</u> , 19 <u>57</u> , to <u>5/25/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/25/57</u> , 19 <u>57</u> , and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE Dr. O. J. Burton - Mitchell				ADDRESS (Street, city, town, state) M.D. Maryland Ave. Salisbury, Maryland			
DATE SIGNED May 27/57							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 28, 1957		NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR MAY 28 1957		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY			
DATE				ADDRESS 957 SALISBURY MARYLAND			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 4 hours after death. The bottom copy shall be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

Reg. No. 144

1. Name of deceased (Print or Write)

2. Sex (Male or Female)

3. Date of Birth

4. Place of Birth

5. Usual Residence

6. Date of Death

7. Time of Death

8. Cause of Death

9. Place of Death

10. Signature of Physician

11. Signature of Registrar

BUREAU V. 3

MAY 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05694

CERTIFICATE OF DEATH

05686

337

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland		c. LENGTH OF STAY IN 1b 1 mo. 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS Chance, Maryland 19x02	
3. NAME OF DECEASED (Type or print) Laura Virginia France		4. DATE OF DEATH Month May Day 4 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1, 1869
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 8 Days 19 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY unk	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Shores		14. MOTHER'S MAIDEN NAME Elizabeth (unk)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk		16. SOCIAL SECURITY NO. unk	
17. INFORMANT Hospital Records		Address Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) A S C V D DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old Fracture of rt. femur		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. 11 Month 19 Day 19 Year 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 27 , 19 57 , to May 4 , 19 57 , that I last saw the deceased alive on May 4 , 19 57 , and that death occurred at 5:20 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED May 5, 1957			
ACTUAL SIGNATURE L. V. Maldve		M.D. Salisbury, Maryland	
PHYSICIAN'S NAME (Type) L. V. Maldve, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-7-57	
22c. NAME OF CEMETERY OR CREMATORY Chance Cemetery		22d. LOCATION (City, town, or county) (State) Chance Md	
23. FUNERAL DIRECTOR'S SIGNATURE Levin B. Wilson		ADDRESS Prince Georges	
24a. REC'D BY REGISTRAR MAY 10 1957		24b. REGISTRAR'S SIGNATURE Mary H. Hallaway	

BUREAU V. S.

MAY 10 1957

RECEIVED

CERTIFICATE OF DEATH

05739

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Fruitland		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Fruitland			
HOSPITAL OR INSTITUTION OR STREET ADDRESS P.O.B.# (Wicomico Hunt Club)				STREET ADDRESS P.O.B.# (Wicomico Hunt Club)			
3. NAME OF DECEASED (Type or Print) EDWARD STEVENSON FURBUSH				4. DATE OF DEATH (Month) May (Day) 18th (Year) 19 57			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH April 26, 1897	9. AGE last birthday 60 yrs.	IF UNDER 1 YEAR Months 0 Days 22	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner & Operator of Riding Stable			10b. KIND OF BUSINESS OR INDUSTRY Berlin, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME Edward Furbush				14. MOTHER'S MAIDEN NAME Charlotte Elizabeth Tarr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Charlotte Schmierer (Daughter) Fruitland, Maryland		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
181X IMMEDIATE CAUSE (A) Carcinoma of Bladder with				INTERVAL BETWEEN ONSET AND DEATH 5-10 mos.			
ANTECEDENT CAUSE(S) DUE TO (B) wide spread metastases							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 1/11 and 1/24		19b. MAJOR FINDINGS OF OPERATION Cancer of Bladder		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12-11-56 , 19 56 , to 5-18 , 19 57 , that I last saw the deceased alive on 5-18-57 , 19 57 , and that death occurred at 3:53P M., from the causes and on the date stated above.							
SIGNATURE Dr. Raymond Yow				ADDRESS (Street, city, town, state) Camden Ave. Salisbury, Maryland			
DATE May 21, 1957				DATE SIGNED May 21, 1957			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 21, 1957		NAME OF CEMETERY OR CREMATORY Ever Green Cemetery		LOCATION (City, town, or county) (State) Berlin, Maryland	
24. REC'D BY REGISTRAR DATE 5/23/57		REGISTRAR'S SIGNATURE Mary Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND			

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy shall be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

Reg. No. 12

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the Department of Health, at Baltimore, Maryland, this 23rd day of May, 1957.

Witness my hand and the seal of the Department of Health, at Baltimore, Maryland, this 23rd day of May, 1957.

Witness my hand and the seal of the Department of Health, at Baltimore, Maryland, this 23rd day of May, 1957.

Witness my hand and the seal of the Department of Health, at Baltimore, Maryland, this 23rd day of May, 1957.

Witness my hand and the seal of the Department of Health, at Baltimore, Maryland, this 23rd day of May, 1957.

Witness my hand and the seal of the Department of Health, at Baltimore, Maryland, this 23rd day of May, 1957.

Witness my hand and the seal of the Department of Health, at Baltimore, Maryland, this 23rd day of May, 1957.

Witness my hand and the seal of the Department of Health, at Baltimore, Maryland, this 23rd day of May, 1957.

Witness my hand and the seal of the Department of Health, at Baltimore, Maryland, this 23rd day of May, 1957.

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Witness my hand and the seal of the Department of Health, at Baltimore, Maryland, this 23rd day of May, 1957.

Witness my hand and the seal of the Department of Health, at Baltimore, Maryland, this 23rd day of May, 1957.

Witness my hand and the seal of the Department of Health, at Baltimore, Maryland, this 23rd day of May, 1957.

BUREAU V. 5

MAY 23 1957

RECEIVED

London Ave. Baltimore

West Green Cemetery

MAY 21 1957

Baltimore

RECEIVED - DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No.

05740

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wetipquin</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE W. GALE</u>				4. DATE OF DEATH Month Day Year <u>May 15 19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 30, 1862</u>	9. AGE (In years lost birthday) <u>95</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>1 15</u>	IF UNDER 24 HRS. Hours Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ephriem Stewart</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Hopkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-14-6242</u>		17. INFORMANT <u>Roy Gale, Jesterville, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>420.0</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 Year</u> <u>5 years</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>8/10</u> , 19 <u>52</u> to <u>5/15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/15</u> , 19 <u>57</u> , and that death occurred at <u>9:30 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Saunders</u>				ADDRESS (Street, city or town, state) <u>Nanticoke, Md.</u>		DATE SIGNED <u>5/17/57</u>	
PHYSICIAN'S NAME (Type) <u>Richard H. Saunders</u>				<u>Nanticoke, Maryland</u>		<u>5/18/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Community Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Wetipquin, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. S. Messing</u>				ADDRESS <u>Bivalve, Maryland</u>		24a. REC'D BY REGISTRAR <u>June 6 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary H. Hollaway</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		SEX Male	
AGE 45		DATE OF BIRTH 1912	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Clerk	
MARITAL STATUS Married		DATE OF MARRIAGE 1935	
NAME OF SPOUSE Jane Doe		PLACE OF MARRIAGE Baltimore, Md.	
CAUSE OF DEATH Heart Disease		PLACE OF DEATH Baltimore, Md.	
DATE OF DEATH June 5, 1957		TIME OF DEATH 10:00 AM	
SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF WITNESS <i>Jane Doe</i>	
SIGNATURE OF PHYSICIAN <i>Dr. John Smith</i>		SIGNATURE OF CORONER <i>John Doe</i>	

BUREAU V. S.

JUN 6 1957

RECEIVED

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05689

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Salisbury				TOWN Pittsville (Rural)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS R.D.# 1 (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
ANNIE LEE GORDY				May 3 rd 19 57			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
Female	White	Married	December 9, 1879	77	4 24		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
House work at Home			None		Pittsville, Maryland		U S A
13. FATHER'S NAME Greensbury Truitt				14. MOTHER'S MAIDEN NAME Hannah White			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
No						Mr. Clarence W. Gordy (Husband) R.D.# 1 Pittsville, Maryland	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) Coronary Artery Thrombosis				INTERVAL BETWEEN ONSET AND DEATH 1 day			
ANTECEDENT CAUSE(S) DUE TO (B) Coronary Atherosclerosis				4 yrs.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 260x Diabetes Mellitus							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 25, 19 57 to May 2, 19 57 , that I last saw the deceased alive on May 2, 19 57 , and that death occurred at 12:15A , from the causes and on the date stated above.							
SIGNATURE Dr. David J. Gilmore				ADDRESS (Street, city, town, state) Medical Center-Salisbury, Maryland DATE SIGNED 5/4/57			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 5, 1957		NAME OF CEMETERY OR CREMATORY Line Church Cemetery		LOCATION (City, town, or county) (State) Sussex Co. Del. (Near Pittsville Maryland)	
24. RECORD BY REGISTRAR MAY 6 1957		REGISTRAR'S SIGNATURE Mary J. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND ADDRESS Maryland			

00:00:00

2010/10/16

100

what I did

2010-11-10 10:10:10

MAY 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05741

CERTIFICATE OF DEATH

05690

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar				c. LENGTH OF STAY IN 1b 50 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 304 East Street				d. STREET ADDRESS 304 East Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mildred Middle Miller Last Gravenor				4. DATE OF DEATH Month May Day 29 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH June 19, 1892	
9. AGE (In years lost birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Sussex County, Del	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Elijah H. Miller				14. MOTHER'S MAIDEN NAME Bertie Caulk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 221-03-8973		17. INFORMANT Howard Gravenor, Delmar, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Hypertension & Arteriosclerosis (c) INTERVAL BETWEEN ONSET AND DEATH One in sleep 6:35							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 1 , 19 57 , to May 29 , 19 57 , that I lost saw the deceased alive on May 20 , 19 57 , and that death occurred at 4:4 M. from the causes and on the date stated above.							
ACTUAL SIGNATURE S. H. Lynch				ADDRESS (Street, city or town, state) Delmar, Del.			
PHYSICIAN'S NAME (Type) S. H. Lynch				DATE SIGNED May 30			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 1, 1957		22c. NAME OF CEMETERY OR CREMATORY Firemans		22d. LOCATION (City, town, or county) (State) Sharptown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. S. Gannell Co - Delmar, Del.				ADDRESS Delmar, Del.		24. RECEIVED BY REGISTRAR JUN 3 1957	
25. REGISTRAR'S SIGNATURE H. S. Gannell							

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		Jan 15, 1912	
Place of Birth		Cause of Death		Date of Death		Time of Death	
New York City		Heart Disease		Jan 18, 1957		10:30 AM	
Usual Residence		Occupation		Manner of Death		Place of Death	
123 Main St, Baltimore, MD		Teacher		Natural		Home	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 3

JUN 3 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland				c. LENGTH OF STAY IN 1b 1 mo. 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alexander Middle Bradford Last Haddaway				4. DATE OF DEATH Month May Day 19 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 7, 1870	
9. AGE (In years last birthday) yrs. 86		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unk		10b. KIND OF BUSINESS OR INDUSTRY unk		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Thomas Haddaway			
14. MOTHER'S MAIDEN NAME Schultz				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. unk				17. INFORMANT Hospital Records Address Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Cononary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) ASCV Disease (c) Arteriosel. generalized							INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 432.1							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from Apr. 17, 1957 , to May 19, 1957 , that I last saw the deceased alive on May 19, 1957 , and that death occurred at 7:00 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE L. V. Maldve				ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED May 19, 1957			
PHYSICIAN'S NAME (Type) L. V. Maldve, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 5-21-1957		22c. NAME OF CEMETERY OR CREMATORY Tieghman		22d. LOCATION (City, town, or county) (State) Tieghman Talbot Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James M. Tieghman ADDRESS				24a. REC'D BY REGISTRAR May 21/57		24b. REGISTRAR'S SIGNATURE May 21/57	

RECEIVED

1. PLACE OF DEATH a. COUNTY, <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishop - RURAL</u> 23X2.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMORY A. Hastings</u>		4. DATE OF DEATH Month Day Year <u>MAY 29 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 3, 1873</u>
9. AGE (In years last birthday) yrs. <u>83</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MAIL CARRIER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM M. HASTINGS</u>		14. MOTHER'S MAIDEN NAME <u>LENORA C. WORKMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>NO.</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT Address <u>LENORA HASTINGS, BISHOPS, MARYLAND</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-11</u> , 19 <u>57</u> , to <u>5-29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5-29-57</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Gilmore</u>		ADDRESS (Street, city or town, state) <u>Medical Center, Salisbury, Md.</u>	
PHYSICIAN'S NAME (Type) <u>David J. Gilmore</u>		DATE SIGNED <u>5/30/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-2-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ODDFELLOWS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BISHOPVILLE MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry A. Wagon</u>		ADDRESS <u>ROCKHOLME, MD.</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 3 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Worcester

Marjorie

Worcester

Worcester

Worcester General Hospital

Worcester

Worcester

Worcester General Hospital

BUREAU V. 3

JUN 3 1952

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy shall be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05693

CERTIFICATE OF DEATH

05742

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eden (Near Fruitland)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eden (Near Fruitland)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D.# 1				STREET ADDRESS (If rural give location) R.D.# 1			
3. NAME OF DECEASED (Type or Print) OLEVIA ELIZABETH ELLEN HASTINGS				4. DATE OF DEATH (Month) May (Day) 8th (Year) 19 57			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Oct. 3, 1874	9. AGE last birthday 82 yrs.	IF UNDER 1 YEAR Months 26 Days 5	IF UNDER 24 HRS. Hours 5 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Wicomico Co. Md. (Salisbury)		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Wilkinson				14. MOTHER'S MAIDEN NAME Mary O'Brien			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Marion Ardis - 501 Liberty St. Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A)				Cerebral Hemorrhage		2 days	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-2, 1957, to 5-8-57, 1957, that I last saw the deceased alive on 5-8-57, 1957, and that death occurred at 9:30 AM, from the causes and on the date stated above.							
SIGNATURE Dr. Lee Lawry				ADDRESS (Street, city, town, state) Fruitland, Maryland		DATE SIGNED May 9, 1957	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 11, 1957		NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Mary J. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND			

MAY 10 1957

CERTIFICATE OF DEATH

Form No. 1

1. Name of deceased (Print or type)

2. Date of death (Month, day, year)

3. Place of death (City, town, or village)

4. Age (Years, months, days)

5. Sex (Male or Female)

6. Race (White, Negro, or Other)

7. Cause of death (Immediate)

8. Cause of death (Underlying)

9. Signature of physician

10. Signature of registrar

11. Date of registration

BUREAU V. 2

MAY 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05698

CERTIFICATE OF DEATH

Reg. Dist. No.

05694

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>md</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill 23x02</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>J.</u> Last <u>Heane</u>				4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 25-1880</u>	
9. AGE (In years, first birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>10</u>		IF UNDER 24 HRS. Hours <u>11</u> Min. <u>40</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Newark, md</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Daniel P. Jones</u>				14. MOTHER'S MAIDEN NAME <u>Sallie E. Primer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mr William J. Heane, Snow Hill, md</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.2 Degenerative Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>422.2</u> DUE TO (c) <u>422.2</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>5-5-</u> , 19 <u>57</u> , to <u>5-5-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5-5-</u> , 19 <u>57</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Worrell's, Jr</u> DATE SIGNED <u>May 7 1957</u>							
ACTUAL SIGNATURE <u>Worrell's, Jr</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF <u>May 10 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wheaton Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Jones, Snow Hill, md</u>				24. REC'D BY REGISTRAR <u>May 7 1957</u>			
24b. REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>							

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, and cause of death. The form is mostly blank with some faint, illegible markings.

BUREAU V. 5

MAY 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05695

05699

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>no Sharptown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL Hospital</u>				d. STREET ADDRESS <u>Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NORMAN</u> Middle <u>D.</u> Last <u>HILL</u>				4. DATE OF DEATH Month <u>May</u> Day <u>4</u> Year <u>197</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 30, 1885</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Customs Inspector (rtd) U. S. Govt.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. Govt.</u>							
13. FATHER'S NAME <u>George W. Hill</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Deibel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>		17. INFORMANT Address <u>Mrs. Ruth A. Hill - Main St., Sharptown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Fibrosis</u> <u>525X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/13/57</u> , 19 <u>57</u> , to <u>5/4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/4/57</u> , 19 <u>57</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilber R. Ellis Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u>		DATE SIGNED <u>5/5/57</u>	
PHYSICIAN'S NAME (Type) <u>Wilber R. Ellis Jr. Medical Center, Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/8/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons - Balto.</u>				24a. REC'D BY REGISTRAR DATE <u>5/6/57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary K. Holloway</u>	

BUREAU A. R.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. To burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

2

MEDICAL CERTIFICATION

2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
05700		MEDICAL EXAMINER'S CERTIFICATE OF DEATH				05696				
Item 9 FilmG216 6-17-57 et										
Reg. Dist. No. 332										
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin 23x12</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>					d. STREET ADDRESS <u>P.J.D.</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Hazel</u> Middle <u>Holston</u> Last <u>Hunkapillar</u>					4. DATE OF DEATH Month <u>5</u> Day <u>7</u> Year <u>1957</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 6, 1909</u>		9. AGE (In years last birthday) <u>47 1/2</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery store.</u>		11. BIRTHPLACE (State or foreign country) <u>NEWARK, MD</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>ZADOCK W. HOLSTON</u>					14. MOTHER'S MAIDEN NAME <u>LOTTIE TOWNSEND</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Mrs. JOHN ITUNKAPILLAR, BERLIN, MD.</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bullet wound of Brain</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflicted</u>							
20c. TIME OF INJURY Month, Day, Year <u>Hour 7:15 a.m. 5-7 1957</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Berlin Worcester Md.</u>		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>Earl L. Royer</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					<u>5-10-57</u>
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOWEN</u>			22d. LOCATION (City, town, or county) <u>NEWARK MD.</u>			(State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna D. Burbage Berlin Md.</u>					ADDRESS <u>Berlin Md.</u>		24a. REC'D BY REGISTRAR <u>Mary Hallaway</u>		24b. REGISTRAR'S SIGNATURE <u>5/14/57</u>	

BP

WISCONSIN STATE DEPARTMENT OF HEALTH—BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V.

1957

LIVE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 6216 6-17-57 et

05697

05701

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Sidney</u> Middle <u>Hutt</u> Last <u>Hutt</u>		4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1957</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-30-1899</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>2</u> Hours <u>1</u> Min.		IF UNDER 24 HRS. Hours <u>1</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doctor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>NEW HILL</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sidney Hutt</u>				14. MOTHER'S MAIDEN NAME <u>Olebie DALE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-10-8473</u>		17. INFORMANT <u>Margie Hutt</u> Address <u>Carroll</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Acute Dilatation</u> DUE TO <u>Hypertensive Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>10 yrs.</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>490X Robert (Pneumonia Right Lower Lobe)</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 3, 1957</u> to <u>May 5, 1957</u> , that I last saw the deceased alive on <u>May 4, 1957</u> , and that death occurred at <u>10:35 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Herbert Sembly</u>		M.D. <u>Salisbury Md</u>		ADDRESS (Street, city or town, state) <u>575/57</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>G. Herbert Sembly</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-8-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Acres Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Boaker M. West</u>				24a. REC'D BY REGISTRAR DATE <u>6/14/57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 16

BUREAU V. B.

MAY 14 1957

RECEIVED

05702

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 8 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) Merritt Mill Rd.,				d. STREET ADDRESS Merritt Mill Rd.,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) JEROME ABBOTT ISEAR				4. DATE OF DEATH Month 5 Day 7 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 25, 1892	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Salesman				10b. KIND OF BUSINESS OR INDUSTRY Dry Goods		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph Isear				14. MOTHER'S MAIDEN NAME Annie Isear			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) W.W.I (If yes, give war or dates of service) W.W.I				16. SOCIAL SECURITY NO. 227-09-9044		17. INFORMANT Mrs. Pearl Isear, Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 420.1 DUE TO ATHEROSCLEROTIC CORONARY ARTERY DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO ATHEROSCLEROTIC CARDIO VASCULAR DISEASE (b) MANY YEARS (c) MANY YEARS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH Few minutes			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10/26 , 19 56 , to 4/27 , 19 57 , that I last saw the deceased alive on 4/22 , 19 57 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 211 Maryland Ave. DATE SIGNED 5/10/57							
ACTUAL SIGNATURE [Signature]				M.D. Dr. O. J. Burton, M.D.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/10/57		22c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery		22d. LOCATION (City, town, or county) (State) Sharptown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Norman E. Baker				ADDRESS The Hill & Johnson Co. Salisbury, Maryland		24a. REC'D BY REGISTRAR 5-11-57	
24b. REGISTRAR'S SIGNATURE Mary W. Holloway							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

INSTRUCTIONS

1
 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy shall be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05699

CERTIFICATE OF DEATH

Reg. Dist. No. 332

05703

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Pittsville		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS (If rural give location) U.S. Route # 50			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) CHARLES (Middle) COVINGTON (Last) JONES				(Month) MAY (Day) 11 (Year) 19 57			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Mar. 5, 1889	9. AGE last birthday 68 yrs.	IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. Days 6	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) R.D. # Powellville, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Jacob G. Jones				14. MOTHER'S MAIDEN NAME Ellen Adkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. Lee Jones (Son) R.D. # Snow Hill, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) 420.1				Coronary Artery Thrombosis			
ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				Coronary Atherosclerosis			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH 1 day			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 10, 1957 to May 11, 1957 , that I last saw the deceased alive on May 11, 1957 , and that death occurred at 11:13A , from the causes and on the date stated above.							
SIGNATURE Dr. David Gilmore				DATE SIGNED May 14 1957			
M.D. Medical Center- Salisbury, Md.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 13, 1957		NAME OF CEMETERY OR CREMATORY Pittsville, Cemetery		LOCATION (City, town, or county) (State) Pittsville, Maryland	
24. REC'D BY REGISTRAR May Holloway		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND			
DATE 5/14/57							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

Age, Date, Sex

DEATH

PLACE OF DEATH

Place of Birth

Residence

Place of Death

Place of Birth

Place of Death

Place of Birth

Place of Death

Place of Birth

Place of Death

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Place of Death

Place of Birth

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Place of Death

Place of Birth

Place of Death

Place of Birth

Place of Birth

Place of Death

BUREAU V. 2

MAY 16 1957

RECEIVED

Medical Officer

Medical Officer

Medical Officer

Medical Officer

Medical Officer

Medical Officer

Medical Officer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
CERTIFICATE OF DEATH											
Reg. Dist. No. 05700 332											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>						c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>						d. STREET ADDRESS <u>19x22</u>					
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Jones</u> Last <u>Jones</u>						4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1957</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Age <u>37</u> yrs.		9. AGE (In years last birthday) Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Cannery factory Maryland</u>						11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>John Dennis</u>						14. MOTHER'S MAIDEN NAME <u>Maime Jones</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Thomas Dennis Princess Anne Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL EDEMA</u> <u>270x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PITUITARY TUMOR - PROBABLE</u> DUE TO <u>Hypo-Glycemia & cerebral edema due to</u> (c) <u>Atrophy of Pituitary Gland</u>											
INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>6 MONTHS</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-22</u> , 19 <u>57</u> , to <u>5-1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 1</u> , 19 <u>57</u> , and that death occurred at <u>9:42</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED											
ACTUAL SIGNATURE <u>John M. Bloxon III</u> M.D. <u>Salisbury, Maryland</u> <u>May 1, 1957</u>											
PHYSICIAN'S NAME (Type) <u>JOHN M. BLOXON III</u> <u>SALISBURY, MARYLAND</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY				22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>				<u>5/3/57</u>		<u>Wesley</u>				<u>Princess Anne Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Jones Jr</u> ADDRESS <u>Princess Anne Md</u>						24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
<u>5-3-57</u>						<u>5-3-57</u>		<u>Mary W. Holloway</u>			

CERTIFICATE OF DEATH

MAY 6 1957

BUREAU V. S.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
SM 2/57

FOR STATE
HEALTH DEPT.

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05705

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05701

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Salisbury, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>			d. STREET ADDRESS <u>R F D # 5, Quantico Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Della</u> Middle <u>Mae</u> Last <u>Kelley</u>			4. DATE OF DEATH Month <u>5</u> Day <u>23</u> Year <u>19 57</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>March 19, 1920</u>		9. AGE (In years last birthday) <u>37</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>John H. Carr</u>			14. MOTHER'S MAIDEN NAME <u>Della May Lewis</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give reg. or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>***</u>		17. INFORMANT Address <u>Della M. Watkins; Portsmouth, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed chest.</u> <u>823X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driving car that that ran off road and overturned.</u>			
20c. TIME OF INJURY Month. Day. Year <u>4: P. m.</u> <u>5-23-19 57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Dagsboro Road</u>	20f. (City or town) <u>Salisbury</u>	(County) <u>Wicomico</u>	(State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Earl L. Royer</u>			DATE SIGNED <u>5-24-57</u>		
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 27, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>70live Branch Cem.</u>	
22d. LOCATION (City, town, or county) <u>Portsmouth, Virginia</u>		(State) <u>Virginia</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Meaford L. Watson Jr.</u>			ADDRESS <u>Seaford, Delaware</u>		
24. APPROVED BY REGISTRAR <u>MAY 27 1957</u>			DATE <u>May 27 1957</u>		
24b. REGISTRAR'S SIGNATURE <u>Mary H. Sullivan</u>					

RECEIVED

MAY 27 1957

BUREAU V. 31

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy shall be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05702

05706

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS (If rural give location) Delmar Road(Trailer Camp)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) CHARLES		(Middle) FERDINAND		(Last) LAMPE		MAY 7 th 19 57	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Sept. 28, 1881		9. AGE last birthday 75 yrs.	IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Chicken Grower(Poultry)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kansas City Mo.		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Robert C. Lampe				14. MOTHER'S MAIDEN NAME Louise Kamshulte			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
				17. INFORMANT'S ADDRESS Mr. Robert C. Lampe(Son) Stamford Conn. # 9 Meadow Park South			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 4 days			
ANTECEDENT CAUSE(S) DUE TO (B) Cerebral Arteriosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 4, 1957, to May 7, 1957, that I last saw the deceased alive on May 7, 1957, and that death occurred at 6:05 PM, from the causes and on the date stated above.							
SIGNATURE <i>David G. Getman</i>				DATE SIGNED May 9 1957			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF May 9, 1957		NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	
				LOCATION (City, town, or county) Salisbury, Maryland		(State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND			
DATE MAY 10 1957							

CERTIFICATE OF DEATH

NAME OF DECEASED [Name]		SEX [Sex]		AGE [Age]	
PLACE OF BIRTH [Place]		DATE OF BIRTH [Date]		TIME OF BIRTH [Time]	
OCCUPATION [Occupation]		CAUSE OF DEATH [Cause]		PLACE OF DEATH [Place]	
DATE OF DEATH [Date]		TIME OF DEATH [Time]		PLACE OF DEATH [Place]	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]		SIGNATURE OF DECEASED [Signature]	
SIGNATURE OF WITNESS [Signature]		SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]	

BUREAU V. 3

MAY 10 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05703

05707

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS 931 W. Fayette Street			
e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Helen Middle Dora Last Lawrence				4. DATE OF DEATH Month May Day 19 Year 19 57			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Sept. 6, 1909	
9. AGE (In years last birthday) 47 yrs.		10. KIND OF BUSINESS OR INDUSTRY Minester		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Dorsey				14. MOTHER'S MAIDEN NAME Daisy Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unk		17. INFORMANT Hospital Records		Address Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 7 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260 X Diabetes Mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) Salisbury, Maryland		(County) (State)	
21. I certify that I attended the deceased from May 9, 1957 , to May 19, 1957 , that I last saw the deceased alive on May 19, 1957 , and that death occurred at 5:00 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE L. V. Maldve				M.D. Salisbury, Maryland DATE SIGNED May 19, 1957			
PHYSICIAN'S NAME (Type) L. V. Maldve, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 24, 1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		22d. LOCATION (City, town, or county) (State) Ceder Hill Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Katie R. Williams				ADDRESS 322 N. Schroeder St.		24a. REC'D BY REGISTRAR DATE 5/22/57	
				24b. REGISTRAR'S SIGNATURE Mary Hallaway			

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15Q-1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05704

05708

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Salisbury		LENGTH OF STAY (In this place)		CITY OR TOWN Salisbury		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS 124 Delmar Rd (Salisbury Blvd.)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) GEORGE (Middle) ELMER (Last) MADDOX				(Month) MAY (Day) 19th (Year) 19 57			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Sept. 6th, 1900	9. AGE last birthday 56 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
						Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic Auto Sales Garage		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) R.D.# Delmar, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George M. Maddax				14. MOTHER'S MAIDEN NAME Olivia Campbell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Gertrude E. Maddax (Wife) 124 Delmar Road - Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) Coronary occlusion				INTERVAL BETWEEN ONSET AND DEATH 3 days			
ANTECEDENT CAUSE(S) DUE TO (B) Arterio-sclerotic heart disease.				Years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12-27-54 , 19....., to 5-19-57 , 19....., that I last saw the deceased alive on 5-19-57 , 19....., and that death occurred at 8:27P.M. from the causes and on the date stated above.							
SIGNATURE Dr. EARL L. ROYER				DATE SIGNED May 21 / 57			
M.D. Medical Center - Salisbury, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 23, 1957		NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		LOCATION (City, town, or county) (State) Delmar, Delaware	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE May Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY, MARYLAND			
DATE 5/23/57							

CERTIFICATE OF DEATH

1. Name of deceased: **George W. Adams**

2. Date of death: **May 23, 1957**

3. Place of death: **1000 Delaware St. (Baltimore, Md.)**

4. Name of physician: **Dr. J. H. Adams**

5. Name of hospital: **Johns Hopkins Hospital**

6. Sex: **Male**

7. Race: **White**

8. Date of birth: **Sept. 10, 1880**

9. Place of birth: **Baltimore, Maryland**

10. Cause of death: **Heart disease**

11. Manner of death: **Natural**

12. Signature of physician: **Dr. J. H. Adams**

13. Signature of registrar: **Johns Hopkins Hospital**

14. Date of filing: **May 23, 1957**

15. File number: **1000 Delaware St. (Baltimore, Md.)**

16. Name of informant: **George W. Adams**

17. Address of informant: **1000 Delaware St. (Baltimore, Md.)**

18. Date of interview: **May 23, 1957**

BUREAU V. 2

MAY 23 1957

RECEIVED

INMATE NO. 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05709

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u>	
c. LENGTH OF STAY IN 1b <u>6 yr. 8 mo.</u>		d. STREET ADDRESS <u>3230 Westmount Avenue</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Bernard</u> Last <u>Martin</u>		4. DATE OF DEATH Month <u>May</u> Day <u>4</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 6, 1881</u>
9. AGE (In years last birthday) yrs. <u>75</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael Martin</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Vick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unk.</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Arterioscl CVD Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. DUE TO Arterioscl Gen. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome</u>			
INTERVAL BETWEEN ONSET AND DEATH ? ?			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 27</u> , 19 <u>51</u> , to <u>May 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 4</u> , 19 <u>57</u> , and that death occurred at <u>1:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L.V. Maldve</u>		ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>L.V. Maldve, M.D.</u>		DATE SIGNED <u>5/4/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-8-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook Inc. 1217 E. Paul St.</u>		24a. REC'D BY REGISTRAR <u>MAY 7 1957</u>	
ADDRESS <u>57-5-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>	

[illegible]

1

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy shall be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05706

05710

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Riverside Nursing Home				STREET ADDRESS (If rural give location) R.D.# (Delmar Rd)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) ISAAC		(Middle) LEWIS		(Last) MERRITT		(Month) (Day) (Year) May 19 th 19 57	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH November 16, 1866		9. AGE last birthday 90 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Green Run, Md (Worcester Co.)		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Isaac Merritt				14. MOTHER'S MAIDEN NAME Sara Collins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. Isaac L. Merritt (Son) 315 Randolph Ave. Cape Charles, Virginia			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) Arteriosclerotic Cardiovascular Dis.				INTERVAL BETWEEN ONSET AND DEATH 2 yrs +			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 5/18 , 19 56 , to 5/18 , 19 57 , that I last saw the deceased alive on 5/18 , 19 57 , and that death occurred at 12:25A , from the causes and on the date stated above.							
SIGNATURE Dr. Rufus Gardner				ADDRESS (Street, city, town, state) 3218 Div. St. Salisbury, Maryland			
DATE SIGNED May 22/57				DATE SIGNED May 22/57			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 22, 1957		NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR DATE 5/23/57		REGISTRAR'S SIGNATURE Mary Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND			

CERTIFICATE OF DEATH

Reg. Form No. 10

1. Usual Residence of Deceased

2. Place of Death

3. Date of Death

4. Time of Death

5. Cause of Death

6. Manner of Death

7. Age

8. Sex

9. Race

10. Marital Status

11. Occupation

12. Signature of Physician

13. Signature of Registrar

14. Date of Burial

15. Place of Burial

16. Date of Report

17. Signature of Reporter

18. Signature of Registrar

19. Signature of Physician

20. Signature of Registrar

21. Date of Report

22. Signature of Registrar

23. Signature of Physician

24. Signature of Registrar

25. Date of Report

26. Signature of Registrar

27. Signature of Physician

28. Signature of Registrar

29. Date of Report

30. Signature of Registrar

31. Date of Report

32. Signature of Registrar

33. Signature of Physician

34. Signature of Registrar

35. Signature of Physician

36. Signature of Registrar

37. Signature of Physician

38. Signature of Registrar

39. Signature of Physician

40. Signature of Registrar

41. Signature of Physician

42. Signature of Registrar

43. Signature of Physician

44. Signature of Registrar

BUREAU V. 21

MAY 23 1957

RECEIVED

Maryland Memorial Park

May 23, 1957

Reg. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. AISME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
Items 18&21 Film 216 6-3-57											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
05743 Item 2 Film 215 5-24-57 et											
Reg. Dist. No. 332											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Salisbury</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer Head State Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Wilber</u> Last <u>Miller</u>						4. DATE OF DEATH Month <u>5</u> Day <u>12</u> Year <u>19 57</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-23-16</u>		9. AGE (In years last birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>State Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Adolph Miller</u>						14. MOTHER'S MAIDEN NAME <u>Matilda Smith</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW 11</u>						16. SOCIAL SECURITY NO. <u>Adolph Miller, 111 Berthoud St. Park Ridge, N.J.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Barbiturate poisoning</u> 970.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>970.2</u> DUE TO (c) <u>Barbiturate poisoning</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Barbiturate poisoning</u> INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>19</u>											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5-16-57</u>											
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>5/17/1957</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u> 22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>											
23. FUNERAL DIRECTOR'S SIGNATURE <u>Salisbury, Md.</u> ADDRESS <u>Salisbury, Md.</u> 24a. REC'D BY REGISTRAR <u>Mary Holloway</u> 24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>											

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MASSACHUSETTS
COUNTY OF

BUREAU V. S.

MAY 20 1957

RECEIVED

05744

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1 Cor. Main & Walnut			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Clifton R. Mitchell				4. DATE OF DEATH Month Day Year May 27 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-28-1897	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Day Hours Min. 1 29		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant				10b. KIND OF BUSINESS OR INDUSTRY Grocery Store		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME George W. Mitchell				14. MOTHER'S MAIDEN NAME Leona Dashiell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT Address Grace Mitchell, Hebron, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Infarction 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 17 hr							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 1, 1957 , to May 26, 1957 , that I last saw the deceased alive on May 26, 1957 , and that death occurred at 6:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William Emerich M.D.				ADDRESS (Street, city or town, state) Hebron - Md DATE SIGNED May 28-57			
PHYSICIAN'S NAME (Type) William Emerich				Hebron, Maryland 5/28/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/29/57		22c. NAME OF CEMETERY OR CREMATORY Hebron Cemetery		22d. LOCATION (City, town, or county) (State) Hebron, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. S. Messick ADDRESS Bivalve, Maryland				24a. REC'D BY REGISTRAR JUN 6 1957 24b. REGISTRAR'S SIGNATURE Mary K. Hollings			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

JUN 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05711

CERTIFICATE OF DEATH

Reg. Dist. No.

05709

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>200 Priscilla St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Louisa</u> Middle <u>Grace</u> Last <u>Mitchell</u>				4. DATE OF DEATH Month <u>5</u> Day <u>20</u> Year <u>19 57</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-21-1875</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Albert James Benner</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Ann Brownley</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mrs. Albert C. Mitchell-200 Priscilla St. (Son)</u> <u>Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic pyelonephritis</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>Weeks</u> <u>Months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0 Arterio-sclerosis</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov. 19 56</u> to <u>5-20-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5-20-57</u> , 19 <u>57</u> , and that death occurred on <u>5-20-57</u> at <u>11:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.				ADDRESS (Street, city or town, state) <u>407 Camden Ave</u> DATE SIGNED <u>5-20-57</u>			
PHYSICIAN'S NAME (Type) <u>Earl L. Royer, M.D.</u>				22a. REC'D BY REGISTRAR <u>5/23/57</u> 24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>			
22b. DATE THEREOF <u>May 22, 1957</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Louden Park Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY - SALISBURY MARYLAND</u>			

RECEIVED

05712

CERTIFICATE OF DEATH

05710

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>2 Wks.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>W.</u> Last <u>Moore</u>				4. DATE OF DEATH Month <u>May</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-27-1870</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>29</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Oystering</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>							
13. FATHER'S NAME <u>Nicholas Moore</u>				14. MOTHER'S MAIDEN NAME <u>Nellie ----</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>----</u>				16. SOCIAL SECURITY NO. <u>----</u>			
17. INFORMANT Address <u>Mrs. Alma Pusey, 211 Lloyd St., Salisbury Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that I attended the deceased from <u>9/2</u> , 19 <u>55</u> , to <u>5/24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/26</u> , 19 <u>57</u> , and that death occurred at <u>10:30</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>211 Maryland Ave., Salisbury Md.</u> DATE SIGNED <u>5/26/57</u>							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u></u>							
PHYSICIAN'S NAME (Type) <u>O. J. Burton</u>				<u>211 Maryland Ave. 5/26/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/30/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bivalve Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bivalve, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Bivalve, Maryland</u>				24a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>JUN 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUN 6 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05711

05713

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS (If rural give location) R.D.# 2 (Jersey Rd)			
3. NAME OF DECEASED (First) (Middle) (Last) MINNIE PARSONS				4. DATE OF DEATH (Month) (Day) (Year) May 10 th 19 57			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Sept. 29, 1883	9. AGE last birthday 73 yrs.	IF UNDER 1 YEAR Months 7 Days 11		IF UNDER 24 HRS. Hours 11 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Sussex Co. Delaware		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Garrison LeCates				14. MOTHER'S MAIDEN NAME Frances Ellis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. Ernest Parsons (Son R.D.# 2 (Jersey Rd Salisbury, Maryland)			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
260X IMMEDIATE CAUSE (A) Coronary Thrombosis							
ANTECEDENT CAUSE(S) DUE TO (B) Diabetes Mellitus							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Senility							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 4-20-57		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 19 57 , to 5/9 , 19 57 that I last saw the deceased alive on 5/9 , 19 57 , and that death occurred at 5/9 M, from the causes and on the date stated above.							
SIGNATURE Dr. Andrew Mitchell				DATE SIGNED May 10 1957			
ADDRESS (Street, city, town, state) M.D. Maryland Ave. Salisbury, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 12, 1957		NAME OF CEMETERY OR CREMATORY Charity Cemetery		LOCATION (City, town, or county) (State) R.D.# 2 Salisbury, Maryland	
24. REC'D BY REGISTRAR DATE 5/13/57		REGISTRAR'S SIGNATURE Mary Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY, MARYLAND			

CERTIFICATE OF DEATH

Case No.

1. DECEASED'S NAME (Last, first, middle)

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MEDICAL ATTENDANT

11. SIGNATURE

12. DATE OF FILING

13. TIME OF FILING

14. SIGNATURE

15. DATE OF FILING

16. TIME OF FILING

17. SIGNATURE

18. PLACE OF DEATH

19. CAUSE OF DEATH

20. MEDICAL ATTENDANT

21. SIGNATURE

22. DATE OF FILING

23. MEDICAL ATTENDANT

24. SIGNATURE

25. DATE OF FILING

26. TIME OF FILING

27. SIGNATURE

28. DATE OF FILING

BUREAU V. 2

MAY 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

DEATH CERTIFICATE

NO. 12, 1957

DEATH

RECEIVED - BUREAU OF VITALS

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05712

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> <u>12</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pollitts Lane</u>		d. STREET ADDRESS <u>Pollitts Lane</u> <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Parsons</u> Last <u>Parsons</u>		4. DATE OF DEATH Month <u>5</u> Day <u>14</u> Year <u>19 57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>O</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-15-1911</u>
9. AGE (in years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>14</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Timber cutter</u>	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>43 to 44</u>		16. SOCIAL SECURITY NO. <u>252-28-0554</u>	
17. INFORMANT <u>Honorable discharge</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>322.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic alcoholism</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>430.1</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>5-16-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/18/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Fruitland, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart</u>		24a. REC'D BY REGISTRAR <u>5/30/57</u>	
ADDRESS <u>Funeral Home, Salisbury, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>May Farrelly</u>	

BUREAU V. 31

MAY 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05715

CERTIFICATE OF DEATH

Reg. Dist. No. 332

05713

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>3 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Riverside Nursing Home</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u> <u>2342.2</u> ✓	
3. NAME OF DECEASED (Type or print) First <u>EDNA</u> Middle <u>F.</u> Last <u>POLK.</u>		4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 25, 1871</u>
9. AGE (In years lost birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard A. Frazier</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Henry P. Walters, Pocomoke City, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>degenerative heart disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/8/55</u> , 19 <u>57</u> , to <u>5/20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/19</u> , 19 <u>57</u> , and that death occurred at <u>925</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. M. Beardsley</u>		DATE SIGNED <u>5/20/57</u>	
PHYSICIAN'S NAME (Type) <u>E. M. Beardsley</u>		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-28-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry P. Walters</u>		24a. REC'D BY REGISTRAR <u>DATE 5/23/57</u>	
ADDRESS <u>Pocomoke Md</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Hollaway</u>	

1957 MAY 23

RECEIVED
MAY 23 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05716

CERTIFICATE OF DEATH

05714

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN TB <u>10th 11min</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		d. STREET ADDRESS <u>P.O. Box 24</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>J.</u> Last <u>Porter</u>		4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/23/57</u>
9. AGE (In years lost birthday) yrs. <u>10</u> Min. <u>11</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Roy D. Porter</u>		14. MOTHER'S MAIDEN NAME <u>Mary Joanne Archer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr Roy D Porter</u>		Address <u>Snow Hill, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Deleclaus, fetal type</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral atrophic damage</u> DUE TO (c) <u>intrauterine anoxemia (Premature separation with placental abruption)</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prematurity (birth weight 2 lb 2 oz)</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Boat</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/23</u> , 19 <u>57</u> , to <u>5/23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/23</u> , 19 <u>57</u> , and that death occurred at <u>10:45</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. H. Saunders</u> M.D.		ADDRESS (Street, city or town, state) <u>926 N Division St. Salisbury Maryland</u>	
DATE SIGNED <u>May 24 1957</u>			
PHYSICIAN'S NAME (Type) <u>Clayton B. Davis</u>			
23a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 24/57</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Episcopal Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Snow Hill Md</u>	
23e. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton B. Davis</u>		23f. ADDRESS <u>Snow Hill, Md</u>	
24a. REC'D BY REGISTRAR <u>Mary H. Holloway</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	
DATE <u>28 1957</u>			

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RECEIVED

05745

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar			c. LENGTH OF STAY IN 1b 15 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Smullen Nursing Home				d. STREET ADDRESS 600 S.2nd. Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Lorena Middle Last Pote				4. DATE OF DEATH Month May Day 11 Year 1957				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 13, 1883		
9. AGE (In years last birthday) 74 3 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Blizzard				14. MOTHER'S MAIDEN NAME Mellissa Boone				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Robert Pote, Delmar, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 14 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.0 arteriosclerotic heart disease, valvular							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
21. I certify that I attended the deceased from 2/11, 1955 to death , 19 57 , that I last saw the deceased alive on 4/25, 1957 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE Ernest M. Larnore				ADDRESS (Street, city or town, state) Delmar, Del.		DATE SIGNED 5/13/57		
PHYSICIAN'S NAME (Type) ERNEST M. LARNORE								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-14-57		22c. NAME OF CEMETERY OR CREMATORY First Methodist		22d. LOCATION (City, town, or county) (State) Delmar, Delaware		
23. FUNERAL DIRECTOR'S SIGNATURE W.S. Marshall Co - Delmar, Del.				ADDRESS Delmar, Del.		24a. REC'D BY REGISTRAR DATE MAY 16 57		
				24b. REGISTRAR'S SIGNATURE West				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 16 1957

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05717

CERTIFICATE OF DEATH

05716

Reg. Dist. No.

338

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 2103.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS No permanent address. Washington County Home			
3. NAME OF DECEASED (Type or print) First Harry Middle Richmond Last Powell				4. DATE OF DEATH Month May Day 6 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 30, 1887	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Achison R. Powell				14. MOTHER'S MAIDEN NAME Pamiley Ann			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. 217 09 9782A		17. INFORMANT Mr. Harry Friedinger 826 Forest Dr. Hagerstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatosis 150x DUE TO Ca. of esophagus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - DUE TO (c) -						INTERVAL BETWEEN ONSET AND DEATH - -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) - - -						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) - - -					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -	20f. (City or town) -	(County) -	(State) -		
21. I certify that I attended the deceased from Oct. 31, 1956 , to May 6, 1957 , that I last saw the deceased alive on May 6, 1957 , and that death occurred at 1:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 5/6/57 ACTUAL SIGNATURE L. V. Maldve M.D. L. V. Maldve, M. D. Salisbury, Maryland PHYSICIAN'S NAME (Type) L. V. Maldve, M. D. Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 8, 1957	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.			24a. REC'D BY REGISTRAR MAY 10 1957		24b. REGISTRAR'S SIGNATURE Mary T. Holloway		

MEDICAL CERTIFICATION

BUREAU A. S.

MAY 10 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 Film 6216 5-29-57 et

CERTIFICATE OF DEATH

05718

05717

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 82 Peninsula General Hospital				d. STREET ADDRESS 19X1-2 none (State Road)			
3. NAME OF DECEASED (Type or print) First John Middle Bayfield Last Bayfield				4. DATE OF DEATH May 14 1957			
5. SEX male		6. COLOR OR RACE colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1911	
9. AGE (In years last birthday) 46		IF UNDER 1 YEAR Months 14 Days 14 Hours 14 Min. 57		IF UNDER 24 HRS. Months 14 Days 14 Hours 14 Min. 57		IF UNDER 24 HRS. Months 14 Days 14 Hours 14 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farmer			
11. BIRTHPLACE (State or foreign country) Crisfield Maryland				12. CITIZEN OF WHAT COUNTRY? Crisfield Maryland			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 215-16 8988			
17. INFORMANT no				Address no			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Rectum 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Prostate DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 5/11/57 , 19____, to 5/14/57 , 19____, that I last saw the deceased alive on 5/14/57 , 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Carrie I. Hearin M.D.				DATE SIGNED 5/20/57			
PHYSICIAN'S NAME (Type) Dr. Carrie I. Hearin				ADDRESS 226 N. Main St.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		May 17, 1957		Private on farm		Crisfield Md	
23. FUNERAL DIRECTOR'S SIGNATURE Brodehau & Sons				ADDRESS Crisfield, Md		24a. REC'D BY REGISTRAR DATE 5/20/57	
24b. REGISTRAR'S SIGNATURE Mary Holloway							

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		DATE OF DEATH <i>May 15, 1957</i>	
AGE <i>45</i>		SEX <i>Male</i>	
RACE <i>White</i>		EDUCATION <i>High School</i>	
OCCUPATION <i>Teacher</i>		MARITAL STATUS <i>Married</i>	
PLACE OF BIRTH <i>Baltimore, Md.</i>		DATE OF BIRTH <i>May 15, 1912</i>	
PLACE OF DEATH <i>Baltimore, Md.</i>		DATE OF DEATH <i>May 15, 1957</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. K. Smith</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>	
DATE <i>May 15, 1957</i>		TIME <i>10:00 AM</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 05719 Item 2 FilmG216 6-5-57 et
 CERTIFICATE OF DEATH

05718
 334

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
c. LENGTH OF STAY IN 1b <u>2 mon.</u>		d. STREET ADDRESS <u>John B. Parsons Home for Aged</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth Simons Richardson</u>		4. DATE OF DEATH Month Day Year <u>May 28 19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 22, 1877</u>
9. AGE (In years last birthday) yrs. <u>80</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George H. Richardson</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Dailey</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>John B. Parsons Home for Aged, Salisbury, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/28</u> to <u>5/28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/28/57</u> , 19 <u>57</u> , and that death occurred at <u>5:15 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Frederic R. Grammel</u> M.D. <u>Salisbury Md</u> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/30/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Whatcoat Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Snow Hill, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas H. Walker</u>		24a. REC'D BY REGISTRAR <u>31 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Thomas H. Walker</u>

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. DATE OF DEATH		7. PLACE OF BIRTH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

05746

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DELMAR</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 DELMAR RD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1 DELMAR RD.</u>	
3. NAME OF DECEASED (Type or print) <u>CHESTER H. RICKARDS</u>		4. DATE OF DEATH Month <u>5</u> Day <u>26</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/29/1891</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Furniture Dealer.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DELAWARE</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Rickards</u>		14. MOTHER'S MAIDEN NAME <u>IDA LYNCH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MRS. ESTHER RICKARDS DELMAR, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } <u>Right Coronary Thrombotic Status</u> DUE TO (c) <u>1 yr</u>		INTERVAL BETWEEN ONSET AND DEATH <u>few months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 1</u> , 19 <u>57</u> , to <u>Mar 26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Mar 24</u> , 19 <u>57</u> , and that death occurred at <u>MD</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. H. Lynch</u>		ADDRESS (Street, city or town, state) <u>Delmar Del</u>	
PHYSICIAN'S NAME (Type) <u>S. H. Lynch</u>		DATE SIGNED <u>May 28</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/29/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ROXANA</u>	22d. LOCATION (City, town, or county) (State) <u>ROXANA DELAWARE</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WATSON & GRAY FRANKFORD</u>		24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2 12 44

BUREAU V. J.

JUN 3 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SPYROS</u> Middle <u>PAUL</u> Last <u>SARBANES</u>				4. DATE OF DEATH Month <u>5</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 13, 1892</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner Resturant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Food</u>		11. BIRTHPLACE (State or foreign country) <u>Greece</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Paul Sarbanes</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W. I</u>				16. SOCIAL SECURITY NO. <u>213-22-6578</u>		17. INFORMANT <u>Mrs. S.P. Sarbanes, Same</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis</u> DUE TO <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u> years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>57</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u>Salisbury</u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u>July 5-15</u> , 19 <u>50</u> , to <u>5-15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5-14</u> , 19 <u>57</u> , and that death occurred at <u>8 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D. <u>Salisbury, Maryland</u>				DATE SIGNED <u>5/16/1957</u>			
PHYSICIAN'S NAME (Type) <u>Earl L. Royer 407 Camden Ave., Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		22d. LOCATION (City, town, or county) <u>Salisbury, Maryland</u> (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hill & Johnson Co. Salisbury, Maryland</u> ADDRESS <u> </u>				24a. REC'D BY REGISTRAR <u>5-17-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>	

BUREAU V. 5

MAY 20 1957

RECEIVED

05721

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howards</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Snow Hill RD #2</u> 23x02	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby Shockley</u>		4. DATE OF DEATH Month Day Year <u>May 24 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 24 1957</u>
9. AGE (In years last birthday) <u>2</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Woodrow Shockley</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Dale</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Woodrow Shockley</u> Address <u>Snow Hill, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intrauterine Asphyxia</u> 761.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Placental Separation of Placenta</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/24</u> , 1957, to <u>5/24</u> , 1957, that I last saw the deceased alive on <u>5/24</u> , 1957, and that death occurred at <u>2:25</u> PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>312 C Market St. Snow Hill, Md.</u> DATE SIGNED <u>5/24/57</u>	
ACTUAL SIGNATURE <u>Thomas L. Jones, M.D.</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>May 25/57</u>	<u>Friendship</u>	<u>Snow Hill, Md. RD #2</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman H. Rennie</u> ADDRESS <u>Snow Hill, Md.</u>		24a. REC'D BY REGISTRAR <u>May 28 1957</u> 24b. REGISTRAR'S SIGNATURE <u>May 28 1957</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

MAY 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05722

CERTIFICATE OF DEATH

Reg. Dist. No.

05722
332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 2 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS 526 S. Beckford Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Agnes Middle - Last Siegfried				4. DATE OF DEATH Month May Day 1 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 28, 1874	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 1 Days 19 Hours 57 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Norristown, Pa.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Michael Peters				14. MOTHER'S MAIDEN NAME Margaret Peters			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) --		17. INFORMANT Address Deer's Head Hospital Records, Salisbury, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized (c) ?							INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450x --							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from February 27, 19 57 , to May 1, 19 57 , that I last saw the deceased alive on May 1, 19 57 , and that death occurred at 3:05 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE L. V. Maldve, M.D.				ADDRESS (Street, city or town, state) Deer's Head State Hospital			
PHYSICIAN'S NAME (Type) L. V. Maldve, M.D.				DATE SIGNED 5/1/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 5-4-1957		22c. NAME OF CEMETERY OR CREMATORY Fairmount Cemetery		22d. LOCATION (City, town, or county) (State) Fairmount Md	
23. FUNERAL DIRECTOR'S SIGNATURE Lewis R. Wilson				24a. REC'D BY REGISTRAR Mary H. Holloway			
ADDRESS Princess Anne Md				DATE MAY 8 1957			

MAY 8 1957

RECEIVED

1 INSTRUCTIONS TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 48 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05724

CERTIFICATE OF DEATH

Reg. Dist. No. 322

05723

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D.# 1				STREET ADDRESS R.D.# 1		(If rural give location)	
3. NAME OF DECEASED (Type or Print) NOAH THOMAS STEPHENS				4. DATE OF DEATH (Month) (Day) (Year) MAY 21 st 19 57			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Sept. 22, 1977	9. AGE last birthday 79 yrs.	IF UNDER 1 YEAR Months 7 Days 29	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Crawford, Ill.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Lewis Stephens				14. MOTHER'S MAIDEN NAME Susaner Priscilla Misner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, Unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. O. Clayton Whayland (Daughter) R.D.# 1 Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
140X IMMEDIATE CAUSE (A) CARCINOMA LIP WITH METASTASIS				INTERVAL BETWEEN ONSET AND DEATH 2 1/2 YRS			
ANTECEDENT CAUSE(S) DUE TO (B) 							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) 							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12-7 , 19 56 , to MAY 21 , 19 57 , that I last saw the deceased alive on MAY 18 , 19 57 , and that death occurred at 7:25P. M, from the causes and on the date stated above.							
SIGNATURE Dr. John Bloxom				DATE SIGNED May 22/57			
M.D. Medical Center -Salisbury, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 25, 1957		NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR DATE 5/23/57		REGISTRAR'S SIGNATURE Mary Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY, MARYLAND			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

Reg. Gen. No.

DATE OF DEATH

PLACE OF DEATH

Place of Birth

Place of Residence

Place of Death

Place of Death

Place of Death

Place of Birth

Place of Birth

Place of Birth

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BUREAU V. B.

APR 23 1957

RECEIVED

MEDICAL CENTER

MAY 10, 1957

MAY 10, 1957

MAY 10, 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05725	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 33v	
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>					d. STREET ADDRESS <u>722 South Park Drive</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Frances</u> Last <u>Taylor</u>					4. DATE OF DEATH Month <u>5</u> Day <u>6</u> Year <u>19 57</u>						
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-9-1870</u>		9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Wheatley T. Jones</u>					14. MOTHER'S MAIDEN NAME <u>Emiline Jones</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. J. W. White, 722 S. Park Dr. Salisbury, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peripheral circulatory failure</u> <u>902.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Intertrochanteric fracture of right hip</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Hours</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell out of bed at home.</u>							
20c. TIME OF INJURY Hour <u>7:50</u> a. m. <u>PM</u> Month, Day, Year <u>5-5-57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Salisbury</u>		(County) <u>Wicomico</u>		(State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Earl L. Royer</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					<u>5-9-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/8/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bates Memorial Cemetery Snow Hill, Maryland</u>			22d. LOCATION (City, town, or county) (State) <u>Maryland</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas H. Hallaway</u>						ADDRESS <u>Salisbury, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 10 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Hallaway</u>	

RECEIVED

MAY 10 1957

BUREAU V. 2

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy shall be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05726

CERTIFICATE OF DEATH

Reg. Dist. No. 337

05725

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 316 Park Ave				STREET ADDRESS 316 Park Ave.		(If rural give location)	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) GEORGE (Middle) ROLAND (Last) TAYLOR				(Month) May (Day) 28 (Year) 19 57			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH October 3, 1884	9. AGE last birthday 72 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Contractor & Builder			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Wicomico Co. Maryland (Mardela)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Steele Taylor				14. MOTHER'S MAIDEN NAME Nettie Wingate			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Anna W. Taylor (Wife) 316 Park Ave. Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
332X IMMEDIATE CAUSE (A) Cerebral Thrombosis						8 hrs	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5/28 , 19 57 , to 5/28 , 19 57 , that I last saw the deceased alive on 5/28 , 19 57 , and that death occurred at 9:40 P.M. , from the causes and on the date stated above.							
SIGNATURE Dr. Fred Gramse				ADDRESS (Street, city, town, state) S. Division St. Salisbury, Maryland		DATE SIGNED May 1957	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 31, 1957		NAME OF CEMETERY OR CREMATORY Mardela Cemetery		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR JUN 3 1957		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND			

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

LOCAL RESIDENT OR NON-RESIDENT

PLACE OF DEATH

NAME OF DECEASED

SEX

DATE OF BIRTH

EDUCATION

118 East Ave.

118 East Ave.

BY

DATE

1957

1957

1957

1957

1957

VS

October 1, 1954

1954

1954

1954

Wilmington Co. Maryland

Wilmington Co. Maryland

Wilmington Co. Maryland

Wilmington Co. Maryland

Wilmington Co. Maryland

Wilmington Co. Maryland

BUREAU V. 8

JUN 3 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05726

CERTIFICATE OF DEATH

05727

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural #1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 Peninsula General Hospital</u>				d. STREET ADDRESS <u>23X0.2</u>			
3. NAME OF DECEASED (Type or print) First <u>Timley</u> Middle <u>a.</u> Last <u>Thomas</u>				4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 16 - 1889</u> <u>67/7/27</u>	
9. AGE (In years, if UNDER 1 YEAR, IF UNDER 24 HRS. last birthday)		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Clatsop, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>George Kirkland</u>			
14. MOTHER'S MAIDEN NAME <u>Francis Wright</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT Address <u>Mr James C Thomas Snow Hill, md Rural #1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Uremia</u> <u>602 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bilateral ureteral obstruction</u> DUE TO (c) <u>Bilateral ureteral and renal calculi</u>				INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> <u>48 hr.</u> <u>1-5 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>MAY 12</u> , 19 <u>57</u> , to <u>MAY 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>MAY 13</u> , 19 <u>57</u> , and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Raymond M. Youe</u>				ADDRESS (Street, city or town, state) <u>707 Camden Salisbury, md</u>			
PHYSICIAN'S NAME (Type) <u>Raymond M. Youe</u>				DATE SIGNED <u>5/13/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>May 16/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Salisbury Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Accomack County, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Dinnis</u>				ADDRESS <u>Snow Hill, md</u>		24a. REC'D BY REGISTRAR DATE <u>5/14/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. B.

MAY 16 1957

RECEIVED

05727

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>VIRGIE VIRGINIA THORNTON</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 24, 1886</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>CHINCOTEAGUE, VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DANIEL J. JESTER</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>MRS. EMILY FARLOW, SALISBURY MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis - Hypertension</u> DUE TO (c) <u>5-8 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.1</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1949</u> , 19____, to <u>days/death</u> , that I last saw the deceased alive on <u>3-4-57</u> , 19____, and that death occurred at <u>11:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Willards Maryland</u> DATE SIGNED <u>5-6-57</u>							
ACTUAL SIGNATURE <u>Frank Lewis</u> M.D.				PHYSICIAN'S NAME (Type) <u>Frank Lewis</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B-</u>		22b. DATE THEREOF <u>5/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>CHINCOTEAGUE VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Barbary</u> ADDRESS <u>Berlin Md</u>				24. REC'D BY REGISTRAR <u>MAY 8 1957</u> 24a. REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MAY 8 1957

BUREAU V. S.

RECEIVED

05728

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Private Sanitarium				d. STREET ADDRESS Springhill Road			
3. NAME OF DECEASED (Type or print) Ethelyn Wilson Upshur				4. DATE OF DEATH Month May Day 28 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14 - 1877	9. AGE (In years last birthday) 80 3/4 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland Snow Hill	
13. FATHER'S NAME Cephias King Wilson				14. MOTHER'S MAIDEN NAME Julia Knop			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mr Franklin Upshur Address Snow Hill, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Jan. 9 , 19 57 , to 5-30 , 19 57 , that I last saw the deceased alive on 5-29 , 19 57 , and that death occurred at 3:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Philip A Insley M.D.				ADDRESS (Street, city or town, state) Salisbury Md DATE SIGNED 5-30-57			
PHYSICIAN'S NAME (Type) Philip A Insley							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		May 31/57		Protestant Cemetery		Snow Hill, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wayne B. Dimmis				ADDRESS Snow Hill, Md		24a. REC'D BY REGISTRAR MAY 31 1957	
				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. S.

MAY 31 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05729

CERTIFICATE OF DEATH

05730

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>23X02</u>	
3. NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>F.</u> Last <u>Ward</u>		4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 6 - 1897</u>
9. AGE (In years, last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>25</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Millwright</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Singapore Bay</u>	
11. BIRTHPLACE (State or foreign country) <u>Widdowes, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Quett Ward</u>		14. MOTHER'S MAIDEN NAME <u>Sarah E. Pruitt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>400-09-1222</u>	
17. INFORMANT <u>Mrs. Bessie L. Ward</u>		18. ADDRESS <u>Snow Hill, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myeloblastic leukemia</u> 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-29-1957</u> to <u>5-1-1957</u> , that I last saw the deceased alive on <u>5-1-1957</u> , and that death occurred at <u>11:58 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>224 N. Division St. Salisbury, Maryland</u>	
DATE SIGNED <u>5/1/57</u>			
PHYSICIAN'S NAME (Type) <u>Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Franklin Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Greentackville Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter B. Smith</u>		24. REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>	
ADDRESS <u>Snow Hill, Md</u>		DATE <u>May 3 1957</u>	

BUREAU V. J.

MAY 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05731

05747

CERTIFICATE OF DEATH

Reg. Dist. No. 335

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SHARP TOWN</u>		c. LENGTH OF STAY IN 1b <u>40 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SHARP TOWN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ETTA</u> Middle <u>F.</u> Last <u>WARREN</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 13, 1880</u>
9. AGE (In years lost birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>13</u> Hours <u>13</u> Min. <u>13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ALBERT L. Cowdery</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Graham</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>ALTON C. WARREN, Sharpstown Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>1</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1</u> , 19 <u>57</u> to <u>May 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 1</u> , 19 <u>57</u> , and that death occurred at <u>4:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Joseph A. Elliott</u>		M.D.	
PHYSICIAN'S NAME (Type) <u>JOSEPH A. ELLIOTT</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/16/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Silverbrook Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Wilmington, Del</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Williams</u>		ADDRESS <u>Federalburg, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 5/17/57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Owens</u>	

BUREAU V. S.

MAY 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 Film G215 5-10-57 et

CERTIFICATE OF DEATH

05730

05732

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRINCESS ANNE 19X22</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>R.R. 1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William J. Waters SR.</u>				4. DATE OF DEATH Month Day Year <u>MAY 1 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/4/1879</u>	9. AGE (In years last birthday) yrs. <u>78</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Fruit</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>William Waters</u>			
14. MOTHER'S MAIDEN NAME <u>Fannie Nutter</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>220-01-9846</u>				17. INFORMANT <u>William J. Waters</u> Address <u>Princess Anne Md R. 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> <u>154x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of rectum</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 wk.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>3:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William H. Fisher Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>			
PHYSICIAN'S NAME (Type) <u>William H. Fisher Jr.</u>				DATE SIGNED _____			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/5/57</u>		<u>not given</u>		<u>Salisbury, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Fisher Jr.</u>				24a. REC'D BY REGISTRAR <u>5-3-57</u>			
ADDRESS <u>Princess Anne Md</u>				24b. REGISTRAR'S SIGNATURE <u>Mary H. Hall</u>			

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, date, cause of death, and location. The form is mostly blank with some faint, illegible markings.

BUREAU V. S.

MAY 6 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05733	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 332	
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>12 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u> <u>2342.2</u>			d. STREET ADDRESS <u>926 Second St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>											
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>W.</u> Last <u>Watson</u>					4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1957</u>						
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 24, 1884</u>		9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>John Watson</u>					14. MOTHER'S MAIDEN NAME <u>Virginia Stewart</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>218-10-2390</u>		17. INFORMANT Address <u>Mrs Matilda B. Watson, Pocomoke, Md.</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis of Coronary Artery</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>years</u>										INTERVAL BETWEEN ONSET AND DEATH <u>few days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Intertrochanteric Fracture of left Femur (Accidental)</u>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>902.0</u>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>fell from chair at home.</u>								
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>May 5, 1957</u> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Pocomoke City, Worcester Md</u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Kendrick M. Cullough</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED	
EXAMINER'S NAME (Type) <u>Kendrick c. Cullough, M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					acting DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					<u>May 18, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>May 20, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Salem M.E. Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>					ADDRESS <u>Pocomoke, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>5/22/57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>		

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU 711

MAY 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05732

CERTIFICATE OF DEATH

Reg. Dist. No.

05734
332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN TB <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chincoteague</u> <u>83X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>117 Cleveland St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jesse</u> Middle <u>Robert</u> Last <u>Watson</u>				4. DATE OF DEATH Month <u>5</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 28, 1890</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				9b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			
13. FATHER'S NAME <u>Jesse R. Watson Sr.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Andrews</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>225-40-4537</u>		17. INFORMANT Address <u>Thos. Lela Watson, Chincoteague</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis and Hypertension</u> DUE TO (c) <u>Diabetes Mellitis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1 Congestive Heart Failure</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>MAY 21, 1957</u> , to <u>MAY 26, 1957</u> , that I last saw the deceased alive on <u>MAY 26, 1957</u> , and that death occurred at <u>5⁴⁵ P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Thomas C. Hill Jr.</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>May 29-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Chincoteague, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Salyer, Chincoteague</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>6-4-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Margu. Holman</u>			

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1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
05748
CERTIFICATE OF DEATH

05735

Reg. Dist. No.

882

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar c. LENGTH OF STAY IN 1b 1 Yr. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Route 50				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury d. STREET ADDRESS 309 College Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Helen Holloway Weatherhead				4. DATE OF DEATH Month Day Year 5 2 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown Around	
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Leroy Riggin, 418 Penn. Ave., Sal. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/17 , 19 57 , to death , 19 57 , that I last saw the deceased alive on 3/17 , 19 57 , and that death occurred at 8:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Ernest M. Larmore M.D. Delmar, Delmar 5/ /1957 PHYSICIAN'S NAME (Type) Dr. Ernest Larmore, Grove St., Delmar Delaware							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/5/57		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Norman T. Baker ADDRESS The Hill & Johnson Co. Salisbury, Maryland				24a. REC'D BY REGISTRAR DATE 5-6-57		24b. REGISTRAR'S SIGNATURE Mary W. Holloway	

BUREAU V. S.

MAY 8 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Siloam</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X/ Siloam</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt.</u>		d. STREET ADDRESS <u>/ Rt.</u>	
3. NAME OF DECEASED (Type or print) First <u>HERMAN</u> Middle <u>WHITE</u> Last <u>WHEATLEY</u>		4. DATE OF DEATH Month <u>5</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 18, 1884</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Wheatley</u>		14. MOTHER'S MAIDEN NAME <u>Earianna White</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Herman Wheatley</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> DUE TO (b) <u>163x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>6 mon</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>6 mon</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1947</u> , 19 <u>57</u> , to <u>5-19-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5-18-57</u> , 19 <u>57</u> , and that death occurred at <u>5:00A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lee Lawry</u> M.D.		ADDRESS (Street, city or town, state) <u>Fruitland, Maryland</u> DATE SIGNED <u>5/20/1957</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Lee Lawry, Fruitland, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/21/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman T. Baker</u> ADDRESS <u>The Hill & Johnson Co. Salisbury, Maryland</u>		24a. REC'D BY REGISTRAR <u>5-21-57</u>	24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

MAY 23 1957

RECEIVED
JAN 23 1957

05733 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No.

05733
332

1. PLACE OF DEATH o. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DEAL ISLAND</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL</u>		d. STREET ADDRESS <u>19X0.2</u>	
3. NAME OF DECEASED (Type or print) First <u>Issac</u> Middle <u>White</u> Last <u>White</u>		4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>MAL</u>	6. COLOR OR RACE <u>COL</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 18 - 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Deal Island</u>	
11. BIRTHPLACE (State or foreign country) <u>SOMERSET</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Issac White</u>		14. MOTHER'S MAIDEN NAME <u>Julia Roberson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cerebrovascular Disease</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>5/9</u> , 1957, to <u>5/12</u> , 1957, that I last saw the deceased alive on <u>5/12</u> , 1957, and that death occurred at <u>7:50 P.M.</u> , from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>Rufus S. Gardner, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>3215 DIV. ST. SALISBURY, MD</u>
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR.</u>		DATE SIGNED <u>5/12/57</u>
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MAY 16</u>	22c. NAME OF CEMETERY OR CREMATORY <u>JOHN WESLEY</u>
22d. LOCATION (City, town, or county) (State) <u>DEAL ISLAND SOMERSET, MD</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Howard</u> ADDRESS <u>Marion MD</u>		24a. REC'D BY REGISTRAR <u>DATE 5-21-57</u>
		24b. REGISTRAR'S SIGNATURE <u>May W. Hollen</u>

CERTIFICATE OF DEATH

BUREAU V. 3

MAY 23 1957

RECEIVED

MAY 16 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 05738											
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar				c. LENGTH OF STAY IN 1b 10 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Delmar					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural						d. STREET ADDRESS Rural				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bruno Middle Walter Last Wolf						4. DATE OF DEATH Month 5 Day 12 Year 1957					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-16-1900		9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months 5 Days 12 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor				10b. KIND OF BUSINESS OR INDUSTRY Road		11. BIRTHPLACE (State or foreign country) Germany				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Wolf						14. MOTHER'S MAIDEN NAME Marguerite Reich					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 152-18-3097		17. INFORMANT Address Erna Schulte, Delmar, Del.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 322.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Acute alcoholism (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden Hours											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Delmar		20g. (County) Wicomico		20h. (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Earl L. Royer M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Earl L. Royer, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 5-21-57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery				22d. LOCATION (City, town, or county) (State) Delmar, Del.	
23. FUNERAL DIRECTOR'S SIGNATURE W. S. Gorman Co. Delmar						4a. REC'D BY REGISTRAR DATE MAY 24 '57		24b. REGISTRAR'S SIGNATURE W. S. Gorman			

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NEW STATE
(HEALTH) DEPT.

Wiscassee

Belmont

Worcester

1957-10-10

BUREAU V. S.

NEW 24 1957

RECEIVED